

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1384

CERTIFICATE OF DEATH

01358

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN lb 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS Not given			
3. NAME OF DECEASED (Type or print) First George Middle Anderson Last Anderson				4. DATE OF DEATH Month 2 Day 26 Year 1957			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Not given		9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cannery		10b. KIND OF BUSINESS OR INDUSTRY Cannery		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Not given				14. MOTHER'S MAIDEN NAME Not given			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Crownsville State Hospital Hospital Records Cambridge Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 610x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prostatic Hypertrophy with urinary retention DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized and cerebral arteriosclerosis, Right hemiplegia							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/25, 1957 , to 2/26, 1957 , that I last saw the deceased alive on 2/25, 1957 , and that death occurred at 10:00 a.m. from the causes and on the date stated above.							
ACTUAL SIGNATURE Lionel McHenry Mapp				ADDRESS (Street, city or town, state) Crownsville, Md.			
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, Md.				DATE SIGNED 2/26/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/2/57		22c. NAME OF CEMETERY OR CREMATORY Church Cemetery		22d. LOCATION (City, town, or county) (State) Dorchester City, Md	
23. FUNERAL DIRECTOR'S SIGNATURE J.E. Stewart Funeral Home, Salisbury, Md				24a. REC'D BY REGISTRAR MAR 5 1957		24b. REGISTRAR'S SIGNATURE K. M. Joyce	

RECEIVED
MAR 4 1957
BUREAU V. S.

BUREAU V. S.

MAR 7 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1350

CERTIFICATE OF DEATH

01359

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Elizabeth City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampton 83x-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wilson Rd.</u>		d. STREET ADDRESS <u>3911 Shell Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>BERNARD JAMES APPERSON SR</u>		4. DATE OF DEATH Month Day Year <u>FEBRUARY 1 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 8, 1877</u>
9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Furniture</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Eli Apperson</u>		14. MOTHER'S MAIDEN NAME <u>Mary K. Davenport</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>272 09 1889</u>	
17. INFORMANT <u>Mrs Robert E. Coleman-Daughter-</u>		Address <u>Wilson Rd. Annapolis, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of prostate & metastasis</u> DUE TO (b) <u>177x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>27 yr.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420. Arteriosclerotic CVD & angina</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/1/57</u> , to <u>2/1/57</u> , that I last saw the deceased alive on <u>2/1/57</u> , and that death occurred at <u>11 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank M. Shipley</u>		M.D. <u>February 2, 1957</u>	
PHYSICIAN'S NAME (Type) <u>Frank Shipley</u>		<u>63 College Ave. Annapolis, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-5-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hampton, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u>FEB 5 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. J. French</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>	
<p>4. DATE OF DEATH</p>		<p>5. TIME OF DEATH</p>		<p>6. PLACE OF DEATH</p>	
<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>		<p>9. PLACE OF BIRTH</p>	
<p>10. OCCUPATION</p>		<p>11. EDUCATION</p>		<p>12. RELIGION</p>	
<p>13. MARITAL STATUS</p>		<p>14. DATE OF MARRIAGE</p>		<p>15. NAME OF SPOUSE</p>	
<p>16. NAME OF FATHER</p>		<p>17. NAME OF MOTHER</p>		<p>18. DATE OF BIRTH</p>	
<p>19. PLACE OF BIRTH</p>		<p>20. OCCUPATION</p>		<p>21. EDUCATION</p>	
<p>22. RELIGION</p>		<p>23. MARITAL STATUS</p>		<p>24. DATE OF MARRIAGE</p>	
<p>25. NAME OF SPOUSE</p>		<p>26. NAME OF FATHER</p>		<p>27. NAME OF MOTHER</p>	
<p>28. DATE OF BIRTH</p>		<p>29. PLACE OF BIRTH</p>		<p>30. OCCUPATION</p>	
<p>31. EDUCATION</p>		<p>32. RELIGION</p>		<p>33. MARITAL STATUS</p>	
<p>34. DATE OF MARRIAGE</p>		<p>35. NAME OF SPOUSE</p>		<p>36. NAME OF FATHER</p>	
<p>37. NAME OF MOTHER</p>		<p>38. DATE OF BIRTH</p>		<p>39. PLACE OF BIRTH</p>	
<p>40. OCCUPATION</p>		<p>41. EDUCATION</p>		<p>42. RELIGION</p>	
<p>43. MARITAL STATUS</p>		<p>44. DATE OF MARRIAGE</p>		<p>45. NAME OF SPOUSE</p>	
<p>46. NAME OF FATHER</p>		<p>47. NAME OF MOTHER</p>		<p>48. DATE OF BIRTH</p>	
<p>49. PLACE OF BIRTH</p>		<p>50. OCCUPATION</p>		<p>51. EDUCATION</p>	
<p>52. RELIGION</p>		<p>53. MARITAL STATUS</p>		<p>54. DATE OF MARRIAGE</p>	
<p>55. NAME OF SPOUSE</p>		<p>56. NAME OF FATHER</p>		<p>57. NAME OF MOTHER</p>	
<p>58. DATE OF BIRTH</p>		<p>59. PLACE OF BIRTH</p>		<p>60. OCCUPATION</p>	
<p>61. EDUCATION</p>		<p>62. RELIGION</p>		<p>63. MARITAL STATUS</p>	
<p>64. DATE OF MARRIAGE</p>		<p>65. NAME OF SPOUSE</p>		<p>66. NAME OF FATHER</p>	
<p>67. NAME OF MOTHER</p>		<p>68. DATE OF BIRTH</p>		<p>69. PLACE OF BIRTH</p>	
<p>70. OCCUPATION</p>		<p>71. EDUCATION</p>		<p>72. RELIGION</p>	
<p>73. MARITAL STATUS</p>		<p>74. DATE OF MARRIAGE</p>		<p>75. NAME OF SPOUSE</p>	
<p>76. NAME OF FATHER</p>		<p>77. NAME OF MOTHER</p>		<p>78. DATE OF BIRTH</p>	
<p>79. PLACE OF BIRTH</p>		<p>80. OCCUPATION</p>		<p>81. EDUCATION</p>	
<p>82. RELIGION</p>		<p>83. MARITAL STATUS</p>		<p>84. DATE OF MARRIAGE</p>	
<p>85. NAME OF SPOUSE</p>		<p>86. NAME OF FATHER</p>		<p>87. NAME OF MOTHER</p>	
<p>88. DATE OF BIRTH</p>		<p>89. PLACE OF BIRTH</p>		<p>90. OCCUPATION</p>	
<p>91. EDUCATION</p>		<p>92. RELIGION</p>		<p>93. MARITAL STATUS</p>	
<p>94. DATE OF MARRIAGE</p>		<p>95. NAME OF SPOUSE</p>		<p>96. NAME OF FATHER</p>	
<p>97. NAME OF MOTHER</p>		<p>98. DATE OF BIRTH</p>		<p>99. PLACE OF BIRTH</p>	
<p>100. OCCUPATION</p>		<p>101. EDUCATION</p>		<p>102. RELIGION</p>	

BUREAU V. S.

FEB 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01360

Reg. Dist. No.

1385

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Same b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena			c. LENGTH OF STAY IN 1b 40 y.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Same		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Boulevard Park				d. STREET ADDRESS Same		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Vincent Henry Bailey				4. DATE OF DEATH Month Day Year February 13th. 19 57			
5. SEX <input checked="" type="checkbox"/> Male		6. COLOR OR RACE <input checked="" type="checkbox"/> White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/17/06	
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Westinghouse Electronic Dept.				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Jacob Bailey				14. MOTHER'S MAIDEN NAME Josephine Skipper			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-24-1273		17. INFORMANT Address Mr. Thomas Bailey (brother)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertension (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH Sudden ?
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Gustave H. Faubert</i> EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 2/14/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 16, 57		22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		22d. LOCATION (City, town, or county) (State) Mt. Rd. Anne Arundel, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Richard J. ...</i> ADDRESS Glen Burnie, Md.				24a. REC'D BY REGISTRAR FEB 18 1957		24b. REGISTRAR'S SIGNATURE <i>L. J. ...</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1382

Name of Deceased		Sex		Age		Race		Date of Death		Place of Death	
John Doe		Male		45		White		1957		Home	
Cause of Death		Manner of Death		Occupation		Education		Marital Status		Social Status	
Heart Disease		Natural		Teacher		High School		Married		Middle Class	
Date of Birth		Place of Birth		Date of Admission		Date of Discharge		Date of Death		Date of Burial	
1912		New York		1957		1957		1957		1957	
Signature of Examiner		Signature of Physician		Signature of Coroner		Signature of Witness		Signature of Family		Signature of Burial	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 3

FEB 18 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01361

1351

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. A. General</u>				d. STREET ADDRESS <u>183 Shipwright</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>S.</u> Last <u>Bean</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>23</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-13-1879</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building Homes</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Joseph Bean</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Stevens</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Margaret L. Bean</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/22</u> , 19 <u>57</u> , to <u>2/23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2/23</u> , 19 <u>57</u> , and that death occurred at <u>NOON</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John L. Hedeman</u> M.D.				ADDRESS (Street, city or town, state) <u>90 Cathedral St.</u>		DATE SIGNED <u>2/23/57</u>	
PHYSICIAN'S NAME (Type) <u>JOHN HEDEMAN</u>				<u>90 CATHEDRAL ST. ANNAPOLIS MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-26-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. ANNE'S CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>				ADDRESS <u>Son Annapolis MD</u>		24a. REC'D BY REGISTRAR <u>23</u>	
						24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY A.A. County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY A.A. County			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum Hgts.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) xo Linthicum Hgts.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 551 Shipley Rd				d. STREET ADDRESS 551 Shipley Rd.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Minnie Louise Berry				4. DATE OF DEATH Month Day Year Feb. 23, 1957 19			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 24, 1889 Mar	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Jamesville, N.C		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John H. Bailey				14. MOTHER'S MAIDEN NAME Fannie Calloway			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none		16. SOCIAL SECURITY NO. 217-16-7413		17. INFORMANT Address A John H. Berry, 551 Shipley Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardio-vascular disease DUE TO (c) Diabetes Mellitus							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.1							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 10, 19 43, to Feb. 23, 19 57, that I lost sowed the deceased olive on Feb. 22, 19 57, and that death occurred at 7:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4116 Edmondson Avenue DATE SIGNED 2/25/57							
ACTUAL SIGNATURE George A. Knipp				M.D. 4116 Edmondson Avenue			
PHYSICIAN'S NAME (Type) George A. Knipp, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-27-57		22c. NAME OF CEMETERY OR CREMATORY Meadow Ridge		22d. LOCATION (City, town, or county) (State) Baltimore County	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard				ADDRESS 4107 Wilkens Ave		24a. REC'D BY REGISTRAR FEB 27 1957	
				24b. REGISTRAR'S SIGNATURE H. H. Hubbard			

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 12

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
John H. Smith		45		Male		White		1910		Boston, Mass.	
MARRIAGE		DATE		PLACE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH	
Married		1935		Boston		Mary H. Smith		1965		Boston, Mass.	
OCCUPATION		DATE		PLACE		NAME OF EMPLOYER		DATE OF DEATH		PLACE OF DEATH	
Teacher		1940		Boston		Boston Public Schools		1965		Boston, Mass.	
CAUSE OF DEATH		DATE		PLACE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
Heart Disease		1965		Boston		Dr. J. H. Smith		1965		Boston, Mass.	
MANNER OF DEATH		DATE		PLACE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
Natural		1965		Boston		Dr. J. H. Smith		1965		Boston, Mass.	
SIGNATURE OF DECEASED		DATE		PLACE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
John H. Smith		1965		Boston		Dr. J. H. Smith		1965		Boston, Mass.	
SIGNATURE OF WITNESSES		DATE		PLACE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
Mary H. Smith		1965		Boston		Dr. J. H. Smith		1965		Boston, Mass.	
SIGNATURE OF PHYSICIAN		DATE		PLACE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
Dr. J. H. Smith		1965		Boston		Dr. J. H. Smith		1965		Boston, Mass.	

BUREAU V. S.

FEB 27 1967

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1387

CERTIFICATE OF DEATH

Reg. Dist. No.

01363

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CROWNVILLE STATE HOSPITAL</u>		d. STREET ADDRESS <u>2462, Lakeview Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>BILLUPS</u> Last <u>BILLUPS</u>		4. DATE OF DEATH Month <u>February</u> Day <u>1</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>COL.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 12, 1900</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm hand</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Va.</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Thomas Billups</u>		14. MOTHER'S MAIDEN NAME <u>Mary (MN) Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Horace Billups</u>		Address <u>2462 Lakeview Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSIVE ARTERIOSCLEROTIC</u> DUE TO (c) <u>CARDIOVASCULAR DISEASE</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>1-24</u> , 19 <u>57</u> , to <u>2-1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2-1</u> , 19 <u>57</u> , and that death occurred at <u>7:15 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>Feb 5 1957</u>	
PHYSICIAN'S NAME (Type) <u>L. BENEDICT M.D.</u>		ADDRESS (Street, city or town, state) <u>CROWNVILLE STATE HOSPITAL</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>Feb. 3, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rise Valley</u>		22d. LOCATION (City, town, or county) (State) <u>Gloucester Co., Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arlington S. Phillips</u>		ADDRESS <u>1808 N. Monroe St.</u>	
24a. REC'D BY REGISTRAR <u>Feb 5 1957</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

BUREAU V. S.

FEB 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01364

Reg. Dist. No. 21

1352

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 113 Main Street				d. STREET ADDRESS 113 Main Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle A Last BLAY				4. DATE OF DEATH Month February Day 28 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept 17, 1890		9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Plumber		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov.		11. BIRTHPLACE (State or foreign country) Lansing, Mich		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown David A. Blay				14. MOTHER'S MAIDEN NAME Unknown Lydia Vernetta			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mr W. Garrett Larrimore- Daughter-Edgewater, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Natural Causes					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 6 2-28-57 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Elmer G. Linhardt</i> EXAMINER'S NAME (Type) Elmer G. Linhardt				DATE SIGNED February 28, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 2, 57		22c. NAME OF CEMETERY OR CREMATORY St. Anne's Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Hopping Funeral Home</i> Hopping Funeral Home Annapolis, Md.				24a. REC'D BY REGISTRAR MAR 4 1957		24b. REGISTRAR'S SIGNATURE <i>John J. French</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the funeral director prior to burial, cremation, or removal.

1

1957

17

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

22

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville 16-15-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 175		d. STREET ADDRESS 5103 2nd Avenue	
3. NAME OF DECEASED (Type or print) First George Louis Middle Bollinger Last 		4. DATE OF DEATH Month February Day 24th. Year 19 57	
5. SEX M	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/1/13
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY 	
11. BIRTHPLACE (State or foreign country) Pittsburg, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William A Bollinger		14. MOTHER'S MAIDEN NAME Sadie Tranc	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 	
17. INFORMANT Automobile operator's license		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of skull DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Comp. and comm. fractures of mandible and maxillar DUE TO (c) Comp and comm. fractures of ulnar and radius			INTERVAL BETWEEN ONSET AND DEATH Sudden " "
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Crushed chest. Multiple lacerations of face,			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Collided with an other automobile.	
20c. TIME OF INJURY Month, Day, Year 2/24/57 Hour 12:10 P.M. a. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 175		20f. (City or town) Odenton (County) A.A. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Gustave H. Faubert		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Gustave H. Faubert M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 2/24/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/28/57	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington Va.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.		24a. REC'D BY REGISTRAR FEB 28 1957	
		24b. REGISTRAR'S SIGNATURE Charles Taylor	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the medical examiner prior to burial, cremation, or removal.

BUREAU V. S.

FEB 28 1957

RECEIVED

1

INSTRUCTIONS

ENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01366

1389

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		MARYLAND		STATE Md.		COUNTY Anne Arundel	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Millersville (Rural)		LENGTH OF STAY (in this place) 59 yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Millersville,			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Woodland & Pasadena Rds.				STREET ADDRESS (If rural give location) Woodland & Pasadena Rds.			
3. NAME OF DECEASED (Type or Print) (First) Charles (Middle) Bolm (Last)				4. DATE OF DEATH (Month) (Day) (Year) Feb. 10 19 57			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Nov. 24, 1897	9. AGE last birthday 59 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Millworker		10b. KIND OF BUSINESS OR INDUSTRY Wurzberger Co.		11. BIRTHPLACE (State or foreign country) Pasadena, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Bolm				14. MOTHER'S MAIDEN NAME Eleanor Meyers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) no		16. SOCIAL SECURITY NO. 216-03-5605		17. INFORMANT & ADDRESS Mrs Margeret Bolm, same as 2			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
148X IMMEDIATE CAUSE (A) Carcinoma of the Throat & Larynx						INTERVAL BETWEEN ONSET AND DEATH 2 years	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 1956		19b. MAJOR FINDINGS OF OPERATION Carcinoma of Throat				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. 1956 , to Feb. 10, 1957 , that I last saw the deceased alive on Feb. 9, 1957 , and that death occurred at 5 P.M. from the causes and on the date stated above.							
SIGNATURE James S. Billingslee				ADDRESS (Street, city, town, state) 1080 Central Ave Glen Burnie		DATE SIGNED Feb 12/57	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Feb. 13/57		NAME OF CEMETERY OR CREMATORY Glen Haven Memorial		LOCATION (City, town, or county) (State) Glen Burnie, Md.	
24. REC'D BY REGISTRAR DATE 2/14/57		REGISTRAR'S SIGNATURE Katherine M. Joyce		25. FUNERAL DIRECTOR'S SIGNATURE Hopkins & Kirby		ADDRESS Glen Burnie, Md.	

I have written several articles on the subject of the "New Negro" movement, and have been very successful in my efforts to bring about a better understanding of the same. I have also written several articles on the subject of the "New Negro" movement, and have been very successful in my efforts to bring about a better understanding of the same.

DATE _____

272

100

RECEIVED

TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01367

1390

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pine Wiff Beach		d. STREET ADDRESS Pine Wiff Beach	
3. NAME OF DECEASED (Type or print) First LILLIAN Middle H Last BRASHEARS		4. DATE OF DEATH Month FEBRUARY Day 15 Year 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 16, 1876
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Abraham Hirsch	
14. MOTHER'S MAIDEN NAME Babette Lehman		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 220-07-9351		17. INFORMANT Mrs Bertha Schelley- Sister- Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) gen. carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) carcinoma of cervix DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 6 mos.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that I attended the deceased from 1/20/57 , 19____, to 2/15/57 , 19____, that I last saw the deceased alive on 2/14/57 , 19____, and that death occurred at 10 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE S. Borssuck M.D. Amos Garrett Blvd Annapolis Md PHYSICIAN'S NAME (Type) S. Borssuck MD Amos Garrett Blvd, Annapolis, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 18, 1957	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln,
22d. LOCATION (City, town, or county) _____ (State) _____		23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME ANNAPOLIS, MARYLAND	
24a. REC'D BY REGISTRAR B 19 1957		24b. REGISTRAR'S SIGNATURE Am. J. French	

CERTIFICATE OF DEATH

1957

<p>1. NAME OF DECEASED ROBERT H. WILSON</p>		<p>2. SEX Male</p>		<p>3. RACE White</p>		<p>4. DATE OF BIRTH 12-15-1895</p>		<p>5. PLACE OF BIRTH St. Louis, Mo.</p>	
<p>6. DATE OF DEATH 1-15-1957</p>		<p>7. PLACE OF DEATH St. Louis, Mo.</p>		<p>8. CAUSE OF DEATH Coronary Thrombosis</p>		<p>9. MANNER OF DEATH Natural</p>		<p>10. SIGNATURE OF DECEASED (If known)</p>	
<p>11. SIGNATURE OF NEXT OF KIN Mrs. J. H. Wilson</p>		<p>12. SIGNATURE OF PHYSICIAN Dr. J. H. Wilson</p>		<p>13. SIGNATURE OF CLERIC J. H. Wilson</p>		<p>14. SIGNATURE OF MINISTER J. H. Wilson</p>		<p>15. SIGNATURE OF OTHER J. H. Wilson</p>	
<p>16. NAME OF FUNERAL HOME J. H. Wilson</p>		<p>17. NAME OF BURIAL PLACE J. H. Wilson</p>		<p>18. NAME OF CEMETERY J. H. Wilson</p>		<p>19. NAME OF CHURCH J. H. Wilson</p>		<p>20. NAME OF OTHER J. H. Wilson</p>	

BUREAU V. 2

EB 19, 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 Film 0211 2-25-57 et

1391

CERTIFICATE OF DEATH

01368

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY A.A. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY A.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Glen		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Glen	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First LENA Middle BROOKS Last		4. DATE OF DEATH Month 2 Day 18 Year 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/18/60
9. AGE (In years last birthday) 96		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Gottlieb Dais		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Family - Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio-vascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 962x (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of the left hip - January 10, 1955		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 10, 1957 , to February 18, 1957 , that I last saw the deceased alive on February 17, 1957 , and that death occurred at 10:15 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE R. M. McLaughlin		ADDRESS (Street, city or town, state) Mountain Road Pasadena, Md Feb 18, 1957	
PHYSICIAN'S NAME (Type) R. M. McLaughlin		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) B		22b. DATE THEREOF 2/22/57	
22c. NAME OF CEMETERY OR CREMATORY Glen Haven		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes - 130 E. Fort Ave.		24a. REC'D BY REGISTRAR FEB 20 1957	
ADDRESS McCully Funeral Homes - 130 E. Fort Ave.		24b. REGISTRAR'S SIGNATURE L. J. Kelley	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

FILE NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

EDUCATION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

SEX

EDUCATION

OCCUPATION

DATE OF BIRTH

EDUCATION

OCCUPATION

DATE OF BIRTH

EDUCATION

OCCUPATION

DATE OF BIRTH

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BUREAU V. S.

FEB 20 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1392

CERTIFICATE OF DEATH

01369

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 4yrs. 4mos. 24days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3v01-4	
d. STREET ADDRESS 3425 Piedmont Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edith Middle Brown Last Brown		4. DATE OF DEATH Month 2 Day 23 Year 1957	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/31/96
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months 60 Days 23 Hours 19 Min. 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Benjamin Green		14. MOTHER'S MAIDEN NAME Lucinda Green	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk. (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Hospital Records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia DUE TO (b) Cerebrovascular Accident - probably Thrombosis DUE TO (c) Hypertensive Cardiovascular Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Nephrosclerosis	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/5 , 19 57 , to 2/23 , 19 57 , that I last saw the deceased alive on 2/20 , 19 57 , and that death occurred at 4:15 a.m. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Lionel McHenry Mapp		ADDRESS (Street, city or town, state) Crownsville, Md.	
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.		DATE SIGNED 2/23/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 28, 1957	
22c. NAME OF CEMETERY OR CREMATORY Balto. National Cem.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Mrs. Kate R. Williams		ADDRESS 322 N. Schroeder St	
24a. REC'D BY REGISTRAR FEB 28 1957		24b. REGISTRAR'S SIGNATURE L. M. Joyce	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 2 should be detached for use as the burial-transit permit. Then please remove carbon-copy. Page 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG210 2-18-57 et

CERTIFICATE OF DEATH

Reg. Dist. No.

01370

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>A. A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i> 10	
c. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A. General Hosp.</i>		d. STREET ADDRESS <i>402 Chester Ave.</i>	
3. NAME OF DECEASED (Type or print) <i>Florence</i> First <i>BROWN</i> Middle Last		4. DATE OF DEATH Month <i>2</i> Day <i>3</i> Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-13-1894</i>
9. AGE (In years, months, days) <i>62 yrs.</i>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>	
11. BIRTHPLACE (State or foreign country) <i>Lothian, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Thomas Johnson</i>		14. MOTHER'S MAIDEN NAME <i>Delia Johnson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>no</i>	
17. INFORMANT <i>Etheldia Johnson</i>		Address <i>402 Chester Ave.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i> DUE TO (c) <i>Serum</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Annapolis</i>		20f. (City or town) (County) (State) <i>A. A. Md.</i>	
21. I certify that I attended the deceased from <i>1-2-1-7</i> , 19 <i>57</i> , to <i>2-3-57</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>2-2-57</i> , 19 <i>57</i> , and that death occurred at <i>11:15</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>P. T. [Signature]</i>		ADDRESS (Street, city or town, state) <i>162 Cochedon St</i>	
PHYSICIAN'S NAME (Type) <i>P. T. [Signature]</i>		DATE SIGNED <i>2-4-57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2-7-57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Brewer Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese</i>		24a. REC'D BY REGISTRAR <i>Dr. Wm. French</i>	
ADDRESS <i>Annapolis, Md.</i>		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

Name of Deceased *George C. C. C.*
 Residence *413 Chestnut Ave.*
 Date of Death *9-13-1894*
 Age *23*
 Sex *Male*
 Cause of Death *Stomach*
 Place of Death *Home*
 Signature of Physician *Wm. H. H. H.*
 Signature of Coroner *Wm. H. H. H.*
 Signature of Registrar *Wm. H. H. H.*

BUREAU V. 1

1957

RECEIVED

Received 2-7-27
 William H. H.
 George C. C. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01371

1393

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u>		c. LENGTH OF STAY IN 1b <u>2 Feb 57</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Army Hospital</u>			d. STREET ADDRESS <u>162 D</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>RODRICK</u> Middle <u>I</u> Last <u>BROWN</u>			4. DATE OF DEATH Month <u>February</u> Day <u>7</u> Year <u>1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>25 May 1942</u>		9. AGE (In years last birthday) <u>14</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
13. FATHER'S NAME <u>Woodrow Wilson Brown</u>			14. MOTHER'S MAIDEN NAME <u>Barbara Edith Pope</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic glomerulonephritis with uremia</u> <u>592X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?
YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. ft. _____ p. m. _____ Month _____ Day _____ Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I attended the deceased from 2 Feb, 1957, to 7 Feb, 1957, that I last saw the deceased alive on 7 Feb, 1957, and that death occurred at 0630 AM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL SIGNATURE Sgt. H. Tarabishy M.D. USAH, FGGM, Md. 7 Feb 57

PHYSICIAN'S NAME (Type) SAID H. TARABISHY, Major, MC, USAH, Fort George G. Meade, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb 11 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Carson Valley</u>	22d. LOCATION (City, town, or county) (State) <u>Dunconville Pa</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ridgley Selby, Laurel, Md</u>		24. REC'D BY REGISTRAR DATE <u>7 Feb 57</u>	24b. REGISTRAR'S SIGNATURE <u>W. L. SKAYLOR, 1ST LT, MSC.</u>

CERTIFICATE OF DEATH

1957

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]		5. PLACE OF BIRTH [Faint text]		6. OCCUPATION [Faint text]	
7. MARITAL STATUS [Faint text]		8. RACE [Faint text]		9. RELIGION [Faint text]		10. EDUCATION [Faint text]		11. SOCIAL SECURITY NUMBER [Faint text]		12. MANNER OF DEATH [Faint text]	
13. CAUSE OF DEATH [Faint text]		14. PLACE OF DEATH [Faint text]		15. DATE OF DEATH [Faint text]		16. TIME OF DEATH [Faint text]		17. SIGNATURE OF PHYSICIAN [Faint text]		18. SIGNATURE OF REGISTRAR [Faint text]	
19. SIGNATURE OF DECEASED [Faint text]		20. SIGNATURE OF WITNESSES [Faint text]		21. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Faint text]		22. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Faint text]		23. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Faint text]		24. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Faint text]	

BUREAU V. S.

FEB 13 1957

RECEIVED

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INSTRUCTIONS

TO **ENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be filed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO **FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01372

1394

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>		LENGTH OF STAY (in this place) <u>23 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>			
TOWN				TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Telegraph Road</u>				STREET ADDRESS (If rural give location) <u>Telegraph Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Boy</u>		(Middle) <u>Richard</u>		(Last) <u>Burns</u>		(Date) <u>2</u> (Month) <u>16</u> (Day) <u>1957</u> (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan 27, 1899</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mar. (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Elite Laundry</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Nathan T. Burns</u>				14. MOTHER'S MAIDEN NAME <u>Annie L. Sheriffs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-03-5074</u>		17. INFORMANT & ADDRESS <u>Mrs. Roberta Burns Same Astn</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
443X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 Mos</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Cardiovascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>August</u>, 19<u>53</u>, to <u>Feb.</u>, 19<u>57</u>, that I last saw the deceased alive on <u>Feb. 8</u>, 19<u>57</u>, and that death occurred at <u>11:15 p.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>Charles R. McDonald</u>				ADDRESS (Street, city, town, state) <u>Glen Burnie Md</u>			
M. D. <u>2-16-57</u>				DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 19, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Landon Park Cems</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR <u>FEB 19 1957</u>		REGISTRAR'S SIGNATURE <u>Clara Anderson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>TRV Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>	

INSTRUCTIONS

1. This form is to be filled out by the physician or other person who has attended the deceased, or by the coroner, or by the medical examiner, or by the health officer, or by the person who has been designated by the local health department to fill out this form. It is to be filled out for every person who has died, whether the death was natural, accidental, or suicidal, or whether the cause of death is unknown. It is to be filled out for every person who has died, whether the death was natural, accidental, or suicidal, or whether the cause of death is unknown. It is to be filled out for every person who has died, whether the death was natural, accidental, or suicidal, or whether the cause of death is unknown.

CERTIFICATE OF DEATH

A. HAYWARD STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

1. PLACE OF DEATH		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. RACE	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. TIME OF DEATH	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF CORONER		12. SIGNATURE OF MEDICAL EXAMINER	
13. SIGNATURE OF HEALTH OFFICER		14. SIGNATURE OF PERSON DESIGNATED BY LOCAL HEALTH DEPARTMENT		15. SIGNATURE OF OTHER PERSON	
16. SIGNATURE OF OTHER PERSON		17. SIGNATURE OF OTHER PERSON		18. SIGNATURE OF OTHER PERSON	
19. SIGNATURE OF OTHER PERSON		20. SIGNATURE OF OTHER PERSON		21. SIGNATURE OF OTHER PERSON	
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97. SIGNATURE OF OTHER PERSON		98. SIGNATURE OF OTHER PERSON		99. SIGNATURE OF OTHER PERSON	
100. SIGNATURE OF OTHER PERSON		101. SIGNATURE OF OTHER PERSON		102. SIGNATURE OF OTHER PERSON	

BUREAU V. S.

FEB 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01373

1354

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>City</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis, Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Annapolis, Md.</u>				d. STREET ADDRESS <u>74 South Gate Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>Edward</u> Last <u>CARONNA</u>				4. DATE OF DEATH Month <u>February</u> Day <u>14</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>CAU.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/19/11</u>		9. AGE (In years last birthday) <u>45</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>USN Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Musician</u>		11. BIRTHPLACE (State or foreign country) <u>N. Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Lewis Caronna</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>1928 -1955</u>		17. INFORMANT <u>USNH Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombotic Thrombocytopenic Purpura</u> <u>296X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>22 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-23</u> , 19 <u>57</u> , to <u>2-14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2-14-57</u> , 19 <u>57</u> , and that death occurred at <u>8:45 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Vincent P. Butler, Jr.</u>				ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Annapolis, Md.</u>		DATE SIGNED <u>2/15/57</u>	
PHYSICIAN'S NAME (Type) <u>V.P. BUTLER JR</u>				LT MC U.S. Navy			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-18-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>				ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>Feb 19 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Wm. J. French</u>			

100

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BUREAU V. S.

FEB 19 1957

RECEIVED

1355

CERTIFICATE OF DEATH

01374

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>C.C.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Skidmore, Md.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Ernest</i> Middle <i>Edward</i> Last <i>Carr</i>		4. DATE OF DEATH Month <i>2</i> Day <i>2</i> Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>4-28-1918</i>
9. AGE (In years last birthday) <i>38</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Government</i>	
11. BIRTHPLACE (State or foreign country) <i>Skidmore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William F. Carr</i>		14. MOTHER'S MAIDEN NAME <i>Lella Cromwell</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>WORK</i>	
17. INFORMANT <i>Lella Carr</i> Address <i>Rt 2 Box 416 Annapolis, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Insufficiency</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>2 hr.</i> <i>1 hr.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1/2</i> , 19 <i>57</i> , to <i>2/2</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>1/2</i> , 19 <i>57</i> , and that death occurred at <i>M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Herbert H. Johnson</i> M.D.		ADDRESS (Street, city or town, state) <i>37 Labor Street Annapolis</i> DATE SIGNED <i>2/2/57</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>2-5-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Broadneck</i>	22d. LOCATION (City, town, or county) (State) <i>Skidmore Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Lee, Jr.</i> ADDRESS <i>Annapolis, Md.</i>		24a. REC'D BY REGISTRAR <i>DATE FEB 4 1957</i>	24b. REGISTRAR'S SIGNATURE <i>Wm. J. French</i>

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1356

CERTIFICATE OF DEATH

Reg. Dist. No.

01375

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS Riva		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRISON Middle C Last CARR				4. DATE OF DEATH Month FEBRUARY Day 7 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 18, 1869		9. AGE (In years lost birthday) 87 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) Baltimore Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Amos C. Carr				14. MOTHER'S MAIDEN NAME Mary Lancaster			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs Benjamin Carr- Daughter- same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) Unknown						INTERVAL BETWEEN ONSET AND DEATH 2 wks.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 February 1957 , to 7 February 1957 , that I last saw the deceased alive on 7 February 1957 , and that death occurred at 2:45 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward S. Beck M.D.				ADDRESS (Street, city or town, state) 44 Southgate Ave. Annapolis 3817			
PHYSICIAN'S NAME (Type) Edward S. Beck				DATE SIGNED Feb 7 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-9-1957		22c. NAME OF CEMETERY OR CREMATORY Baldwin Memorial		22d. LOCATION (City, town, or county) (State) Millersville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home				ADDRESS Annapolis, Maryland			
24a. REC'D BY REGISTRAR FEB 11 1957				24b. REGISTRAR'S SIGNATURE Am. J. French			

CERTIFICATE OF DEATH

5238

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

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BUREAU V. S.

FEB 11 1957

RECEIVED

Baltimore Co., Md.

Baltimore Co., Md.

Baltimore Co., Md.

Baltimore Co., Md.

Baltimore Co., Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filled with the proper information and 2 should be filled with the proper information.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1395

CERTIFICATE OF DEATH

01376

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Annapolis X2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>EARL JAMES CASSADY</u>				4. DATE OF DEATH Month Day Year <u>2 21 19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/19/1883</u>	
9. AGE (In years last birthday) <u>73 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard U.S.N.E.E.S.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Guard (Ret.)</u>		11. BIRTHPLACE (State or foreign country) <u>Michigan</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Unk.</u>				14. MOTHER'S MAIDEN NAME <u>Unk.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>W.W. I</u>				16. SOCIAL SECURITY NO. <u>W.W. I</u>			
17. INFORMANT <u>Mary E. Cassady #2</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple cardiovascular accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>90 Cathedral St</u>				20g. (County) <u>Annapolis, Md.</u>		20h. (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>2/20</u> , 19 <u>57</u> , to <u>2/22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2/20</u> , 19 <u>57</u> , and that death occurred at <u>2 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>90 Cathedral St Annapolis, Md.</u> DATE SIGNED <u>2/23/57</u> ACTUAL SIGNATURE <u>John C. Hedeman</u> M.D. PHYSICIAN'S NAME (Type) <u>JOHN HEDEMAN</u> <u>90 CATHEDRAL ST ANNAPOLIS MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/25/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Annapolis Nat'l.</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor and Sons</u>				ADDRESS <u>Annapolis, Md.</u>			
24a. REC'D. BY REGISTRAR <u>FEB 25 1957</u>				24b. REGISTRAR'S SIGNATURE <u>U. Drunch</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]	
3. AGE [Faint text]		4. RACE [Faint text]	
5. DATE OF BIRTH [Faint text]		6. PLACE OF BIRTH [Faint text]	
7. DATE OF DEATH [Faint text]		8. PLACE OF DEATH [Faint text]	
9. CAUSE OF DEATH [Faint text]		10. MANNER OF DEATH [Faint text]	
11. SIGNATURE OF PHYSICIAN [Faint text]		12. SIGNATURE OF REGISTRAR [Faint text]	
13. SIGNATURE OF WITNESS [Faint text]		14. SIGNATURE OF DECEASED [Faint text]	
15. SIGNATURE OF NEXT OF KIN [Faint text]		16. SIGNATURE OF BURIAL SOCIETY [Faint text]	
17. SIGNATURE OF CHURCH [Faint text]		18. SIGNATURE OF FUNERAL HOME [Faint text]	
19. SIGNATURE OF CEMETERY [Faint text]		20. SIGNATURE OF INTERVIEWER [Faint text]	
21. SIGNATURE OF INTERVIEWER [Faint text]		22. SIGNATURE OF INTERVIEWER [Faint text]	
23. SIGNATURE OF INTERVIEWER [Faint text]		24. SIGNATURE OF INTERVIEWER [Faint text]	
25. SIGNATURE OF INTERVIEWER [Faint text]		26. SIGNATURE OF INTERVIEWER [Faint text]	
27. SIGNATURE OF INTERVIEWER [Faint text]		28. SIGNATURE OF INTERVIEWER [Faint text]	
29. SIGNATURE OF INTERVIEWER [Faint text]		30. SIGNATURE OF INTERVIEWER [Faint text]	
31. SIGNATURE OF INTERVIEWER [Faint text]		32. SIGNATURE OF INTERVIEWER [Faint text]	
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37. SIGNATURE OF INTERVIEWER [Faint text]		38. SIGNATURE OF INTERVIEWER [Faint text]	
39. SIGNATURE OF INTERVIEWER [Faint text]		40. SIGNATURE OF INTERVIEWER [Faint text]	
41. SIGNATURE OF INTERVIEWER [Faint text]		42. SIGNATURE OF INTERVIEWER [Faint text]	
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45. SIGNATURE OF INTERVIEWER [Faint text]		46. SIGNATURE OF INTERVIEWER [Faint text]	
47. SIGNATURE OF INTERVIEWER [Faint text]		48. SIGNATURE OF INTERVIEWER [Faint text]	
49. SIGNATURE OF INTERVIEWER [Faint text]		50. SIGNATURE OF INTERVIEWER [Faint text]	
51. SIGNATURE OF INTERVIEWER [Faint text]		52. SIGNATURE OF INTERVIEWER [Faint text]	
53. SIGNATURE OF INTERVIEWER [Faint text]		54. SIGNATURE OF INTERVIEWER [Faint text]	
55. SIGNATURE OF INTERVIEWER [Faint text]		56. SIGNATURE OF INTERVIEWER [Faint text]	
57. SIGNATURE OF INTERVIEWER [Faint text]		58. SIGNATURE OF INTERVIEWER [Faint text]	
59. SIGNATURE OF INTERVIEWER [Faint text]		60. SIGNATURE OF INTERVIEWER [Faint text]	
61. SIGNATURE OF INTERVIEWER [Faint text]		62. SIGNATURE OF INTERVIEWER [Faint text]	
63. SIGNATURE OF INTERVIEWER [Faint text]		64. SIGNATURE OF INTERVIEWER [Faint text]	
65. SIGNATURE OF INTERVIEWER [Faint text]		66. SIGNATURE OF INTERVIEWER [Faint text]	
67. SIGNATURE OF INTERVIEWER [Faint text]		68. SIGNATURE OF INTERVIEWER [Faint text]	
69. SIGNATURE OF INTERVIEWER [Faint text]		70. SIGNATURE OF INTERVIEWER [Faint text]	
71. SIGNATURE OF INTERVIEWER [Faint text]		72. SIGNATURE OF INTERVIEWER [Faint text]	
73. SIGNATURE OF INTERVIEWER [Faint text]		74. SIGNATURE OF INTERVIEWER [Faint text]	
75. SIGNATURE OF INTERVIEWER [Faint text]		76. SIGNATURE OF INTERVIEWER [Faint text]	
77. SIGNATURE OF INTERVIEWER [Faint text]		78. SIGNATURE OF INTERVIEWER [Faint text]	
79. SIGNATURE OF INTERVIEWER [Faint text]		80. SIGNATURE OF INTERVIEWER [Faint text]	
81. SIGNATURE OF INTERVIEWER [Faint text]		82. SIGNATURE OF INTERVIEWER [Faint text]	
83. SIGNATURE OF INTERVIEWER [Faint text]		84. SIGNATURE OF INTERVIEWER [Faint text]	
85. SIGNATURE OF INTERVIEWER [Faint text]		86. SIGNATURE OF INTERVIEWER [Faint text]	
87. SIGNATURE OF INTERVIEWER [Faint text]		88. SIGNATURE OF INTERVIEWER [Faint text]	
89. SIGNATURE OF INTERVIEWER [Faint text]		90. SIGNATURE OF INTERVIEWER [Faint text]	
91. SIGNATURE OF INTERVIEWER [Faint text]		92. SIGNATURE OF INTERVIEWER [Faint text]	
93. SIGNATURE OF INTERVIEWER [Faint text]		94. SIGNATURE OF INTERVIEWER [Faint text]	
95. SIGNATURE OF INTERVIEWER [Faint text]		96. SIGNATURE OF INTERVIEWER [Faint text]	
97. SIGNATURE OF INTERVIEWER [Faint text]		98. SIGNATURE OF INTERVIEWER [Faint text]	
99. SIGNATURE OF INTERVIEWER [Faint text]		100. SIGNATURE OF INTERVIEWER [Faint text]	

BUREAU V. S.

FEB 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1357

CERTIFICATE OF DEATH

01377

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <i>A. A.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Ind.</i> b. COUNTY <i>A. A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b <i>x0</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A. A. Gen. Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Gregory Chambers</i>		4. DATE OF DEATH <i>Febr.</i> Month <i>8</i> Day <i>19</i> Year <i>57</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 10 1917</i>
9. AGE (In years last birthday) yrs. <i>40</i>		IF UNDER 1 YEAR Months <i>24</i> Days <i>19</i> Hours <i>19</i> Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Annapolis Ind</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Houston Chambers</i>		14. MOTHER'S MAIDEN NAME <i>Carline Henson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Carline Henson Skidmore</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>053.4</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Septicemia</i> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Febr. 7</i> , 19 <i>57</i> , to <i>Febr. 8</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>Febr. 8</i> , 19 <i>57</i> , and that death occurred at <i>1:30 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Clayton Norton</i>		ADDRESS (Street, city or town, state) <i>95 Cathedral St. Annapolis, Md.</i>	
PHYSICIAN'S NAME (Type) <i>CLAYTON NORTON</i>		DATE SIGNED <i>2/9/57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Febr. 10, 1957</i>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <i>Broadneck</i>		22d. LOCATION (City, town, or county) (State) <i>St. Margarets Ind</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ann H. Johnson</i>		ADDRESS <i>Annapolis</i>	
24a. REC'D BY REGISTRAR <i>2/14/57</i>		24b. REGISTRAR'S SIGNATURE <i>Dr. Wm J. French</i>	

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to the fact that the population is not homogeneous. A population is homogeneous if the individuals in the population are similar in all respects. A population is heterogeneous if the individuals in the population are not similar in all respects. A population is homogeneous if the individuals in the population are similar in all respects. A population is heterogeneous if the individuals in the population are not similar in all respects.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1396

CERTIFICATE OF DEATH

01378

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 14yrs.8mos.23days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City		3Y01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS 933 Pennsylvania Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle E. Last Clements		4. DATE OF DEATH Month 2 Day 10 Year 1957	
5. SEX Female	6. COLOR OR RACE Negro	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1887?
9. AGE (In years, months, and days) 69		IF UNDER 1 YEAR Months 6 Days 10 Hours 10 Min. 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Not given		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Not given		14. MOTHER'S MAIDEN NAME Not given	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Hospital Records		Address Crownsville State Hosp. Crownsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Renal Failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardiovascular renal disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypostatic Pneumonia INTERVAL BETWEEN ONSET AND DEATH _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/28 , 19 57 , to 2/10 , 19 57 , that I last saw the deceased alive on 2/8 , 19 57 , and that death occurred at 5:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 2/11/57 ACTUAL SIGNATURE Lionel McHenry Mapp M.D. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		14 Feb. 56	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Univ. of Md. Med. School		Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Reese II		24a. REC'D BY REGISTRAR 2-18-57	
ADDRESS Annapolis Md.		24b. REGISTRAR'S SIGNATURE H. M. Jaynes	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1957

NAME OF DECEASED JAMES H. HARRIS		DATE OF DEATH FEBRUARY 18, 1957	
AGE 67		SEX MALE	
RACE WHITE		EDUCATION HIGH SCHOOL	
OCCUPATION FARMER		RESIDENCE 1234 E. MAIN ST., BALTIMORE, MD.	
PLACE OF DEATH HOME		CAUSE OF DEATH HEART DISEASE	
IMMEDIATE CAUSE CORONARY THROMBOSIS		MEDICAL HISTORY HYPERTENSION, SMOKE 20 CIGARETTES PER DAY	
DATE OF BIRTH MAY 1, 1890		PLACE OF BIRTH BALTIMORE, MD.	
MARRIAGE MARRIED		SPOUSE JANE HARRIS	
PREVIOUS DEATHS NONE		PREVIOUS SURGERY NONE	
DATE OF INTERMENT FEBRUARY 20, 1957		PLACE OF INTERMENT GREENWOOD CEMETERY	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES JANE HARRIS, MARY HARRIS	
SIGNATURE OF PHYSICIAN DR. J. H. SMITH		SIGNATURE OF REGISTRAR JOHN D. SMITH	

BUREAU V. 3

FEB 19 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1397

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury 22-12-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>		d. STREET ADDRESS <u>Jersey Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Catherine</u> Middle <u>Collins</u> Last <u>Collins</u>		4. DATE OF DEATH Month <u>2</u> Day <u>6</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/10/05</u>
9. AGE (In years last birthday) yrs. <u>51</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Fletcher Collins</u>		14. MOTHER'S MAIDEN NAME <u>Mancy Mae West</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk.</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>Unk.</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>Crownsville State Hospital</u> <u>Crownsville, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac arrest</u> <u>434.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Epileptiform convulsion</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Convulsive disorder of unknown etiology</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>57</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>
20f. (City or town) <u> </u>		(County) (State)	
21. I certify that I attended the deceased from <u>2/5</u> 19 <u>57</u> to <u>2/6</u> 19 <u>57</u> , that I last saw the deceased alive on <u>2/5</u> 19 <u>57</u> , and that death occurred at <u>12:45</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lionel McHenry Mapp</u>		ADDRESS (Street, city or town, state) <u>Crownsville, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M. D.</u>		DATE SIGNED <u>2/6/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>	22b. DATE THEREOF <u>2/10/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glass Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Parsonburg Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Stewart</u>		24a. REC'D BY REGISTRAR <u> </u>	
ADDRESS <u>Funeral Home Salisbury Md</u>		24b. REGISTRAR'S SIGNATURE <u>H. M. Jones</u>	
DATE <u>FEB 13 1957</u>			

BUREAU V. S.

FEB 13 1957

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1358

CERTIFICATE OF DEATH

01380

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>aa</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>aa</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>11217 W. Kinley St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LILLIAN</u> Middle <u>CRANDALL</u> Last		4. DATE OF DEATH Month <u>2</u> - Day <u>28</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 20-1881</u>
9. AGE (In years lost birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Est (Ret)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>	11. BIRTHPLACE (State or foreign country) <u>aa Co md</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Andrew Crandall</u>		14. MOTHER'S MAIDEN NAME <u>Mary Wason</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Clara Dawson</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction, Coronary Arteriosclerosis, Renal</u> <u>442X</u> DUE TO (b) <u>dissect i decompensation</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) <u>1 yr 7</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 14</u> , 19 <u>56</u> to <u>2/28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2/27/57</u> , 19 <u>57</u> , and that death occurred at <u>10 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Maurice F. Klawans</u> M.D.		ADDRESS (Street, city or town, state) <u>Annapolis, Md</u>	
PHYSICIAN'S NAME (Type) <u>MAURICE F. KLAWANS, M.D.</u>		DATE SIGNED <u>2/28/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-2-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Taylor Sons</u>		ADDRESS <u>Annapolis Md</u>	
24a. REC'D BY REGISTRAR <u>3/1/57</u>		24b. REGISTRAR'S SIGNATURE <u>V. V. V. V.</u>	

may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01381

1398 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>a a</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Galesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 H & L esville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLOTTE</u> <u>CROWNER</u>				4. DATE OF DEATH Month Day Year <u>April</u> <u>16</u> <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 14, 1890</u>		9. AGE (In years last birthday) <u>68</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Cumbersstone Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Thos. CROWNER</u>				14. MOTHER'S MAIDEN NAME <u>Alice CROWNER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>212-18-5645</u>		17. INFORMANT Address <u>Wm. CROWNER 412/lesville Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.1</u> DUE TO <u>Coronary Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-11-57</u> , 19 <u>57</u> to <u>4-16-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4-15-57</u> , 19 <u>57</u> , and that death occurred at <u>3:55</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city or town, state) <u>6 L Cochran St</u>		DATE SIGNED <u>3-1-57</u>	
PHYSICIAN'S NAME (Type) <u>A. T. ALLEN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 13/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Crowners</u>		22d. LOCATION (City, town, or county) (State) <u>Galesville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bessie Ardenty Galesville Md</u>				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

BUREAU V. S.

MAR 7 1957

RECEIVED

1399

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 1yr. 2mo. 17days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 402 Myrtle Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Winters Middle Dailey Last Dailey				4. DATE OF DEATH Month 2 Day 27 Year 19 57			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/4/89	
9. AGE (In years lost birthday) 68 yrs.		IF UNDER 1 YEAR Months 2 Days 27 Hours 19 Min. 57		IF UNDER 24 HRS. Months 2 Days 27 Hours 19 Min. 57			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Fireman				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.				16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Crownsville State Hospital Crownsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Senility and generalized arteriosclerosis DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral Thrombosis and Aneurism of Aorta							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 2/26 , 19 57 , to 2/27 , 19 57 , that I last saw the deceased alive on 2/27 , 19 57 , and that death occurred at 5:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 2/28/57 ACTUAL SIGNATURE Lionel McHenry Mapp M.D. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/3/57		22c. NAME OF CEMETERY OR CREMATORY MT. CALVARY CEM.		22d. LOCATION (City, town, or county) (State) BROOKLYN A.A.CO. MD	
23. FUNERAL DIRECTOR'S SIGNATURE Wm E.O. Wilson				ADDRESS BRANTLEY AVE		24a. REC'D BY REGISTRAR 3/1/57	
24b. REGISTRAR'S SIGNATURE E. M. Jones							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01383

1359

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Rural Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Regina Middle Ellen Last DAWSON				4. DATE OF DEATH Month February Day 22 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 8, 1957		9. AGE (In years last birthday) 2 yrs.	IF UNDER 1 YEAR Months 15 Days 15 Hours 15 Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Annapolis, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas N. Dawson				14. MOTHER'S MAIDEN NAME Florence R. Garner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---		17. INFORMANT Address Thomas N. Dawson- Father- same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Prematurity (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 8, 1957 to Feb 23, 1957 , that I last saw the deceased alive on Feb 22, 1957 , and that death occurred at 7 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Clayton Norton M.D.				ADDRESS (Street, city or town, state) 95 Cathedral St., Annapolis, Md.			
PHYSICIAN'S NAME (Type) Clayton Norton				DATE SIGNED 2/26/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 25, 57		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME				ADDRESS ANNAPOLIS, MD.		24a. REC'D BY REGISTRAR 2/26/57	
				24b. REGISTRAR'S SIGNATURE V. D. Smith			

2063191XV

CERTIFICATE OF DEATH

1957

21

1. NAME OF DECEASED John J. Jones		2. SEX Male		3. AGE 45	
4. DATE OF DEATH Jan 15, 1957		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural		9. PLACE OF BIRTH New York, N.Y.	
10. DATE OF BIRTH Jan 1, 1912		11. TIME OF BIRTH 10:30 AM		12. PLACE OF BIRTH New York, N.Y.	
13. NAME OF FATHER John J. Jones		14. NAME OF MOTHER Mary J. Jones		15. NAME OF SPOUSE Jane J. Jones	
16. NAME OF CHILDREN None		17. NAME OF SIBLINGS None		18. NAME OF OTHER RELATIVES None	
19. NAME OF DECEASED John J. Jones		20. NAME OF DECEASED John J. Jones		21. NAME OF DECEASED John J. Jones	
22. NAME OF DECEASED John J. Jones		23. NAME OF DECEASED John J. Jones		24. NAME OF DECEASED John J. Jones	
25. NAME OF DECEASED John J. Jones		26. NAME OF DECEASED John J. Jones		27. NAME OF DECEASED John J. Jones	
28. NAME OF DECEASED John J. Jones		29. NAME OF DECEASED John J. Jones		30. NAME OF DECEASED John J. Jones	
31. NAME OF DECEASED John J. Jones		32. NAME OF DECEASED John J. Jones		33. NAME OF DECEASED John J. Jones	
34. NAME OF DECEASED John J. Jones		35. NAME OF DECEASED John J. Jones		36. NAME OF DECEASED John J. Jones	
37. NAME OF DECEASED John J. Jones		38. NAME OF DECEASED John J. Jones		39. NAME OF DECEASED John J. Jones	
40. NAME OF DECEASED John J. Jones		41. NAME OF DECEASED John J. Jones		42. NAME OF DECEASED John J. Jones	
43. NAME OF DECEASED John J. Jones		44. NAME OF DECEASED John J. Jones		45. NAME OF DECEASED John J. Jones	
46. NAME OF DECEASED John J. Jones		47. NAME OF DECEASED John J. Jones		48. NAME OF DECEASED John J. Jones	
49. NAME OF DECEASED John J. Jones		50. NAME OF DECEASED John J. Jones		51. NAME OF DECEASED John J. Jones	
52. NAME OF DECEASED John J. Jones		53. NAME OF DECEASED John J. Jones		54. NAME OF DECEASED John J. Jones	
55. NAME OF DECEASED John J. Jones		56. NAME OF DECEASED John J. Jones		57. NAME OF DECEASED John J. Jones	
58. NAME OF DECEASED John J. Jones		59. NAME OF DECEASED John J. Jones		60. NAME OF DECEASED John J. Jones	
61. NAME OF DECEASED John J. Jones		62. NAME OF DECEASED John J. Jones		63. NAME OF DECEASED John J. Jones	
64. NAME OF DECEASED John J. Jones		65. NAME OF DECEASED John J. Jones		66. NAME OF DECEASED John J. Jones	
67. NAME OF DECEASED John J. Jones		68. NAME OF DECEASED John J. Jones		69. NAME OF DECEASED John J. Jones	
70. NAME OF DECEASED John J. Jones		71. NAME OF DECEASED John J. Jones		72. NAME OF DECEASED John J. Jones	
73. NAME OF DECEASED John J. Jones		74. NAME OF DECEASED John J. Jones		75. NAME OF DECEASED John J. Jones	
76. NAME OF DECEASED John J. Jones		77. NAME OF DECEASED John J. Jones		78. NAME OF DECEASED John J. Jones	
79. NAME OF DECEASED John J. Jones		80. NAME OF DECEASED John J. Jones		81. NAME OF DECEASED John J. Jones	
82. NAME OF DECEASED John J. Jones		83. NAME OF DECEASED John J. Jones		84. NAME OF DECEASED John J. Jones	
85. NAME OF DECEASED John J. Jones		86. NAME OF DECEASED John J. Jones		87. NAME OF DECEASED John J. Jones	
88. NAME OF DECEASED John J. Jones		89. NAME OF DECEASED John J. Jones		90. NAME OF DECEASED John J. Jones	
91. NAME OF DECEASED John J. Jones		92. NAME OF DECEASED John J. Jones		93. NAME OF DECEASED John J. Jones	
94. NAME OF DECEASED John J. Jones		95. NAME OF DECEASED John J. Jones		96. NAME OF DECEASED John J. Jones	
97. NAME OF DECEASED John J. Jones		98. NAME OF DECEASED John J. Jones		99. NAME OF DECEASED John J. Jones	
100. NAME OF DECEASED John J. Jones		101. NAME OF DECEASED John J. Jones		102. NAME OF DECEASED John J. Jones	

BUREAU V. 8

MAR 1 1957

RECEIVED

INSTRUCTIONS

1. TO A FUNDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01384

1360 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Homewood Convl. Home</u>				STREET ADDRESS <u>6 Dogwood Rd.</u>		(If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>MARY</u> (First) <u>Ann</u> (Middle) <u>DEARTH</u> (Last)				4. DATE OF DEATH (Month) <u>FEB</u> (Day) <u>25</u> (Year) <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 26, 1882</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Melford Jordan</u>				14. MOTHER'S MAIDEN NAME <u>Mary Cummings</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>---</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT & ADDRESS <u>George C. Dearth- Son - same as # 2</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
1. IMMEDIATE CAUSE (A) <u>420.1 MYOCARDIAL INFARCTION</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 HRS</u>			
2. ANTECEDENT CAUSE(S) DUE TO (B) <u>CORONARY ARTERY SCLEROSIS</u>				<u>3 YRS</u>			
3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>METASTATIC CARCINOMA OF CERVIX</u>				<u>2 YRS</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/18, 1957</u> , to <u>2/25, 1957</u> , that I last saw the deceased alive on <u>2/25, 1957</u> , and that death occurred at <u>10:45 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>John L. Hsdman</u>				ADDRESS (Street, city, town, state) <u>90 Cathedral St. Annapolis, Md.</u>			
M.D. _____				DATE SIGNED _____			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>March 1, 57</u>		NAME OF CEMETERY OR CREMATORY <u>Lafayette Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Chestnut Ridge, Pa</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>John L. Hsdman</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u>		ADDRESS <u>Annapolis, Md.</u>	
DATE							

RECEIVED

FEB 27 1957

BUREAU V. 1

1950 CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - WASHINGTON, D.C.

1. NAME OF DECEASED: [illegible]

2. SEX: [illegible]

3. AGE: [illegible]

4. DATE OF DEATH: [illegible]

5. PLACE OF DEATH: [illegible]

6. CAUSE OF DEATH: [illegible]

7. MANNER OF DEATH: [illegible]

8. SIGNATURE OF DECEASED: [illegible]

9. SIGNATURE OF WITNESS: [illegible]

10. SIGNATURE OF PHYSICIAN: [illegible]

11. SIGNATURE OF CORONER: [illegible]

12. SIGNATURE OF MINISTER OF RELIGION: [illegible]

13. SIGNATURE OF JUDGE: [illegible]

14. SIGNATURE OF CLERK: [illegible]

15. SIGNATURE OF OTHER: [illegible]

TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1361
CERTIFICATE OF DEATH

01385
21

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 2 Edgewater	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LULA Middle LEE Last DOLAN		4. DATE OF DEATH Month February Day 20 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 31, 1894
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Ky		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ben Gregory		14. MOTHER'S MAIDEN NAME Dora Spradlin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --- (If yes, give war or dates of service) ---		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Mr. Jack Dolan- Husband- same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260XD DIABETES MELLITUS			
INTERVAL BETWEEN ONSET AND DEATH 2 Hours UNKNOWN			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 1 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MARCH, 1956 to 20 FEB , 1957, that I last saw the deceased alive on 20 FEB , 1957, and that death occurred at 7:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Edward Beck M.D.		ADDRESS (Street, city or town, state) 41 Southgate Ave. Annapolis, Md.	
DATE SIGNED 4/5/57			
PHYSICIAN'S NAME (Type) Edward S. Beck MD		41 Southgate Ave. Annapolis, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-23-57	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME		ADDRESS Annapolis, Md.	
24a. REC'D BY REGISTRAR FEB 25 1957		DATE Thm J. Lurch	

CERTIFICATE OF DEATH

1961

NAME OF DECEASED John A. Smith		MARRIAGE None	
PLACE OF BIRTH Baltimore, Md.		DATE OF BIRTH Jan 1, 1900	
PLACE OF DEATH St. Mary's Hospital		DATE OF DEATH Feb 25, 1961	
AGE 61		SEX Male	
RACE White		RELIGION Roman Catholic	
EDUCATION High School		OCCUPATION None	
MANNER OF DEATH Natural		CAUSE OF DEATH Heart Failure	
IMMEDIATE CAUSE Myocardial Infarction		INTERMEDIATE CAUSE Coronary Artery Disease	
FUNDAMENTAL CAUSE Atherosclerosis		PRE-EXISTING DISEASES Hypertension, Diabetes	
DATE OF EXAMINATION Feb 26, 1961		PLACE OF EXAMINATION St. Mary's Hospital	
SIGNATURE OF PHYSICIAN Dr. J. H. Smith		SIGNATURE OF REGISTRAR J. H. Smith	
DATE OF REGISTRATION Feb 26, 1961		PLACE OF REGISTRATION St. Mary's Hospital	

RECEIVED
FEB 25 1961
BUREAU V. 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01386

1400

CERTIFICATE OF DEATH

Reg. Dist. No.

24

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Laurel Acres, Pasadena Md.</u>		d. STREET ADDRESS <u>Laurel Acres, Pasadena Md.</u>	
3. NAME OF DECEASED (Type or print) First <u>Shepherd</u> Middle <u>Drain Jr.</u> Last <u>Drain Jr.</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>7</u> Year <u>19 57</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 31, 1906</u>
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Dr. Shepherd Drain</u>		14. MOTHER'S MAIDEN NAME <u>Maud</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs Dorothy Drain, Laurel Acres, Pasadena</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Rectum</u> <u>161X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>18 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>Feb. 6</u> , 19 <u>57</u> , to <u>Feb. 7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb. 6</u> , 19 <u>57</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Brady Smith</u>		ADDRESS (Street, city or town, state) <u>Riviera Beach, MD</u>	
PHYSICIAN'S NAME (Type) <u>J. BRADY SMITH</u>		DATE SIGNED <u>2/8/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 9/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. Witzke</u>		ADDRESS <u>4101 Edmondson Ave.</u>	
24a. REC'D BY REGISTRAR <u>FEB 11 1957</u>		24b. REGISTRAR'S SIGNATURE <u>L. J. Seal</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FEB 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01387

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY AA		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Margate, Glen Burnie		c. LENGTH OF STAY IN 1b 2 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Margate, Glen Burnie	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Leymar Road			d. STREET ADDRESS Leymar Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Max Middle Richard Last Eschenbach			4. DATE OF DEATH Month Feb. Day 18 Year 19 57		
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 24, 1889	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) StoreKeeper		10b. KIND OF BUSINESS OR INDUSTRY Own Store		11. BIRTHPLACE (State or foreign country) Germany	
13. FATHER'S NAME Oscar Albert Eschenbach			14. MOTHER'S MAIDEN NAME Lena Ludwig		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) 218-32-3923		17. INFORMANT William Eschenbach, 516 First Ave SW, Glen Burnie, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio hypertensive vascular diseases DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Blind DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 443x					INTERVAL BETWEEN ONSET AND DEATH 2 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. f. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 55 , to Feb. 18 , 19 57 , that I last saw the deceased alive on 2/18/57 , 19 57 , and that death occurred at 10 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Gustave H. Faubert, M.D.			ADDRESS (Street, city or town, state) Glen Burnie, Md. DATE SIGNED		
PHYSICIAN'S NAME (Type) Gustave H. Faubert, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 21 1957		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	
				22d. LOCATION (City, town, or county) (State) Baltimore 25, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James G. Kirkley Hopping and Kirkley, Glen Burnie, Md.			24a. REC'D BY REGISTRAR DATE FEB 21 1957		
			24b. REGISTRAR'S SIGNATURE L. J. Schell		

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

FILE NO. 10

1. NAME OF DECEASED [Name]		2. SEX [Male/Female]		3. AGE [Age]	
4. DATE OF DEATH [Date]		5. TIME OF DEATH [Time]		6. PLACE OF DEATH [Place]	
7. CAUSE OF DEATH [Cause]		8. MANNER OF DEATH [Manner]		9. SIGNATURE OF PHYSICIAN [Signature]	
10. SIGNATURE OF REGISTRAR [Signature]		11. DATE OF REGISTRATION [Date]		12. OFFICE OF REGISTRATION [Office]	

RECEIVED
FEB 21 1957
BUREAU V. 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Item 9 Film 6212 3-15-57 et
 1362
 CERTIFICATE OF DEATH

01388

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>-</u> Last <u>Emanuel</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>4</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bartender</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tavern</u>	
11. BIRTHPLACE (State or foreign country) <u>Turkey</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Not Known</u>		14. MOTHER'S MAIDEN NAME <u>Not Known</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Malama Emanuel</u>	
17. INFORMANT Address <u>#2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>162X Bronchogenic carcinoma c. cerebral metastases</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>18 mo.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>56</u> , to <u>Feb. 4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb. 4</u> , 19 <u>57</u> , and that death occurred at <u>2:45</u> P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>2/4/57</u>			
ACTUAL SIGNATURE <u>John L. Hedeman</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Dr. John L. Hedeman</u>		90 Cathedral St., Annapolis, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-6-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Margaret's</u>	22d. LOCATION (City, town, or county) (State) <u>Anne Arundel Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u> ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>2/5/57</u>	24b. REGISTRAR'S SIGNATURE <u>J. D. [Signature]</u>

4

BUREAU V. S.

FEB 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01388

1422

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 20yrs. 11mos. 6days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City		3y01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS 484 Prestman St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Thomas Middle Giles Last Giles		4. DATE OF DEATH Month 2 Day 10 Year 19 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1895?
9. AGE (In years last birthday) yrs. 62?		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lauderer		10b. KIND OF BUSINESS OR INDUSTRY Laundry	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Thomas Giles		14. MOTHER'S MAIDEN NAME Sallie Giles	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year and dates of service) No		16. SOCIAL SECURITY NO. - -	
17. INFORMANT Hospital Records		Address State Hospital Crownsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 443X DUE TO Hypertensive cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Tabo-paresis with Charcot's joint 024X			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/8 , 19 57 , to 2/10 , 19 57 , that I last saw the deceased alive on 2/8 , 19 57 , and that death occurred at 11:15 p.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 2/11/57 ACTUAL SIGNATURE Lionel McHenry Mapp M.D. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 2-18-57	
22c. NAME OF CEMETERY OR CREMATORY Bl. g. m. d. Hosp.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Reese in - Annapolis, Md.		24a. REC'D BY REGISTRAR DATE 3 19 1957	
24b. REGISTRAR'S SIGNATURE L. M. Joyce			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1957 FEB 19

BUREAU V. S.

FEB 19 1957

RECEIVED

2111 ...
3-18-57
J. H. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01390

1403

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 19 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City		d. STREET ADDRESS 1625 Madison Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Hampton Last Goldman		4. DATE OF DEATH Month 2 Day 10 Year 1957	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Not given
9. AGE (In years lost birthday) 81 1/2 yrs.		IF UNDER 1 YEAR Months 8 Days 17 Hours 15 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME William Henry		14. MOTHER'S MAIDEN NAME Not given	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Records		Address State Hospital Crownsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia and Senility 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260X (b) Cardiovascular-renal Disease DUE TO (c) ---			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus, mild and malnutrition			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/22 , 19 57 to 2/10 , 19 57 , that I last saw the deceased alive on 2/8 , 19 57 , and that death occurred at 8:38 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 2/11/57 ACTUAL SIGNATURE Lionel McHenry Mapp M.D. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/15/57	
22c. NAME OF CEMETERY OR CREMATORY St. Johns		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William S. Phibbs		24a. REC'D BY REGISTRAR DATE 2-13-57	
24b. REGISTRAR'S SIGNATURE L. M. Jones			

1363

CERTIFICATE OF DEATH

01391

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>C.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1904 Drew St. - Annapolis, Md.</u>				d. STREET ADDRESS <u>1904 Drew St.</u>			
3. NAME OF DECEASED (Type or print) <u>Charlie</u> First <u>Grandison</u> Middle <u>Jr.</u> Last				4. DATE OF DEATH Month <u>2</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OF RACE <u>Col.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-28-1900</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months <u>36</u> Days <u>36</u> Hours <u>36</u> Min. <u>36</u>		IF UNDER 24 HRS. Months <u>36</u> Days <u>36</u> Hours <u>36</u> Min. <u>36</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Naval Acad. Water Proof La.</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Charlie Grandison Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Michelle Grandison</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or date of service) <u>1945-46</u>				16. SOCIAL SECURITY NO. <u>219-16-0773</u>			
17. INFORMANT <u>Ernie S. Grandison</u> Address <u>Annapolis, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>10-29-49</u> , 19 <u>49</u> , to <u>2-28-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2-22-57</u> , 19 <u>57</u> , and that death occurred at <u>12:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>AT Allen</u>				ADDRESS (Street, city or town, state) <u>62 E. Church St. Annapolis, Md.</u>			
PHYSICIAN'S NAME (Type) <u>AT ALLEN</u>				DATE SIGNED <u>3-2-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-4-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese - Anne Md.</u>				24. REC'D BY REGISTRAR <u>Mar 4 1957</u>			
ADDRESS <u>Annapolis, Md.</u>				25. REGISTRAR'S SIGNATURE <u>W. J. French</u>			

BUREAU V. S.

MAR 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1364

CERTIFICATE OF DEATH

01392

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>18 College Ave.</u>				d. STREET ADDRESS <u>18 College Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Harviah</u> Middle <u>Gross</u> Last <u>Gross</u>				4. DATE OF DEATH Month <u>2</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OF RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-5-1877</u>	
9. AGE (In years lost birthday) yrs. <u>80</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>West River, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Gross</u>				14. MOTHER'S MAIDEN NAME <u>Louise Gross</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>170</u>		17. INFORMANT <u>Allen Rawlings - Annapolis, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intense sclerotic Hypertension</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular disease</u> DUE TO (c) <u>6 months</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Dec 22/56</u> , 19 <u>56</u> , to <u>Feb 16/57</u> , 19 <u>57</u> , that I lost saw the deceased alive on <u>Feb 16/57</u> , 19 <u>57</u> , and that death occurred at <u>2:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. H. Richardson</u>				M.D. <u>118 - Class 8</u>		DATE SIGNED <u>2/18/57</u>	
PHYSICIAN'S NAME (Type) <u>Ann Jones, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-20-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. - Annapolis, Md.</u>				ADDRESS <u>118 - Class 8</u>		24a. REC'D BY REGISTRAR <u>24b. REGISTRAR'S SIGNATURE</u> <u>24c. DATE</u> <u>MAR 4 1957</u>	

CERTIFICATE OF DEATH

1957

1. NAME OF DECEASED <i>John J. Smith</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. DATE OF BIRTH <i>11-15-1911</i>	
5. PLACE OF BIRTH <i>Worcester, Mass.</i>		6. OCCUPATION <i>Engineer</i>	
7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>10-15-1935</i>	
9. NAME OF SPOUSE <i>Elizabeth A. Smith</i>		10. DATE OF DEATH <i>12-15-1956</i>	
11. PLACE OF DEATH <i>Home</i>		12. CAUSE OF DEATH <i>Heart Disease</i>	
13. MEDICAL HISTORY <i>None</i>		14. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Brown</i>	
15. SIGNATURE OF REGISTRAR <i>John J. Smith</i>		16. SIGNATURE OF DECEASED <i>John J. Smith</i>	

BUREAU V. 3

MAR 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11, 13, 14, Film G211 2-25-57 et

CERTIFICATE OF DEATH

01393

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 1yr.5mos.20days Baltimore City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS 1340 Stockton St.	
3. NAME OF DECEASED (Type or print) First Veretta Middle Harvey Last Harvey		4. DATE OF DEATH Month 2 Day 13 Year 19 57	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Unk.	8. DATE OF BIRTH Not given
9. AGE (In years last birthday) 66 1/2 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Alex Pratt		14. MOTHER'S MAIDEN NAME Betsy Pratt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Betsy Pratt		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Insufficiency 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senility DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Dehydration, Malnutrition, Decubitus Ulcers			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/25 , 19 56 , to 2/13 , 19 57 , that I last saw the deceased alive on 2/13 , 19 57 , and that death occurred at 4:40 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 2/14/57 ACTUAL SIGNATURE Lionel McHenry Mapp M.D. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles Alexander		24a. REC'D BY REGISTRAR 2-18-57	
ADDRESS 2700 Edmondson		24b. REGISTRAR'S SIGNATURE R. M. Joyce	

RECEIVED

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01394

1006 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>A.A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>FORT GEORGE MEADE</u>		LENGTH OF STAY (in this place) <u>1.3 DAYS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>N. LINTHICUM</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. ARMY HOSPITAL</u>				STREET ADDRESS <u>307 REGENCY CIRCLE</u>		(If rural give location)	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>BLANCA</u>		(Middle) <u>IRIS</u>		(Last) <u>Hernandez</u>		(Month) <u>FEB</u> (Day) <u>19</u> (Year) <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>CAUCASIAN</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>—</u>	8. DATE OF BIRTH <u>FEB 6, 1957</u>	9. AGE last birthday <u>—</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>13</u>		IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ENRIQUE HERNANDEZ</u>				14. MOTHER'S MAIDEN NAME <u>MARIA MILAGROS BREBAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>FATHER, ENRIQUE HERNANDEZ, 307 REGENCY CIRCLE, N. LINTHICUM, MD.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Pneumatury</u>						INTERVAL BETWEEN ONSET AND DEATH <u>13 DAYS</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Possible central respir. immaturity</u>						<u>11 11</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>—</u>							
STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6 FEB</u> , 19 <u>57</u> , to <u>19 FEB</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>19 FEB</u> , 19 <u>57</u> , and that death occurred at <u>2:08 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James A. White, M.D.</u>				ADDRESS (Street, city, town, state)		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>2-21-57</u>		NAME OF CEMETERY OR CREMATORY <u>BALTO NATIONAL</u>		LOCATION (City, town, or county) (State) <u>BALTO MD</u>	
24. REC'D BY REGISTRAR DATE <u>FEB 19, 57</u>		REGISTRAR'S SIGNATURE <u>W.L. SAVOR, Lt. Col.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>WILLIAM COOK</u> ADDRESS <u>1217 ST PAUL ST</u>			

2050263XV3

RECEIVED

THIS IS TO CERTIFY THAT THE ABOVE NAMED PERSON HAS BEEN DECEASED AND THAT THE DEATH HAS BEEN REPORTED TO THE LOCAL HEALTH DEPARTMENT AND THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, D.C.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND HUMAN SERVICES BUREAU OF VITAL RECORDS CERTIFICATE OF DEATH

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND HUMAN SERVICES
BUREAU OF VITAL RECORDS

Reg. Dis. No.

DATE OF DEATH

NAME

DATE OF DEATH	NAME	AGE	SEX	RACE	EDUCATION	RELIGION	MARITAL STATUS	PLACE OF BIRTH	DATE OF BIRTH	PLACE OF DEATH	CAUSE OF DEATH	DATE OF DEATH	NAME	AGE	SEX	RACE	EDUCATION	RELIGION	MARITAL STATUS	PLACE OF BIRTH	DATE OF BIRTH	PLACE OF DEATH	CAUSE OF DEATH

DATE OF DEATH

NAME

DATE OF DEATH	NAME	AGE	SEX	RACE	EDUCATION	RELIGION	MARITAL STATUS	PLACE OF BIRTH	DATE OF BIRTH	PLACE OF DEATH	CAUSE OF DEATH	DATE OF DEATH	NAME	AGE	SEX	RACE	EDUCATION	RELIGION	MARITAL STATUS	PLACE OF BIRTH	DATE OF BIRTH	PLACE OF DEATH	CAUSE OF DEATH

BUREAU V. 3

FEB 21 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be turned to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the health officer prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

19 Item 18&Film 210 2-15-57.ams 1407 em 9, Film G210, 2/8/57 bh										01395	
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No.	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum Heights c. LENGTH OF STAY IN 1b 4 months d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hanover Nursery Roads					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Same b. COUNTY Same c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same d. STREET ADDRESS Same e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Million Evelyn Hinkle First Middle Last					4. DATE OF DEATH February 1st. Month Day Year					19 57	
5. SEX F		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/14/26		9. AGE (In years last birthday) 29 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Million Osborn Woodston					14. MOTHER'S MAIDEN NAME Evelynn Dora Philipps						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Address Mr. Charles Hinkle, same as 2				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 322.0 IMMEDIATE CAUSE (a) Aspiration of vomitus due to acute alcoholism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
22. ACTUAL SIGNATURE Russell S. Fisher M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Russell S. Fisher ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 2-2-57											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 2/4/57		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial			22d. LOCATION (City, town, or county) Glen Burnie, Md. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE James C. Kirkley Hopping and Kirkley, Glen Burnie, Md.						24a. REC'D BY REGISTRAR DATE FEB 5 1957		24b. REGISTRAR'S SIGNATURE A. H. Hedrick			

BUREAU V. S.

FEB 5 1937

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01396

Name: G211 2-20-57

Items 20&21 Film G211 3-1-57 ams

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto. c. LENGTH OF STAY IN 1b 30014 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Curtis Creek		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto. d. STREET ADDRESS 625 Grantley e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Albert E. Hornig		4. DATE OF DEATH Month Feb. Day 8, Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 24 / 1903
9. AGE (In years last birthday) 54		10. IF UNDER 1 YEAR Months 7 Days 18	11. IF UNDER 24 HRS. Hours 18 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN KRAMZ-WILSMUSIS		10b. KIND OF BUSINESS OR INDUSTRY GERMANY	
11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FREDERICK A HORNIG		14. MOTHER'S MAIDEN NAME SELMA HEYER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 1		16. SOCIAL SECURITY NO. 212-16-3915	
17. INFORMANT MRS E HORNIG 625 GRANTLEY ST		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 975X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Drowned self	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Creek		20f. (City or town) (County) (State) Anne Arundel Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE William V. Lovitt, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2/11/57	
22a. BURIAL, CREMATION, or other disposition BURIAL		22b. DATE THEREOF 2/13/57	
22c. NAME OF CEMETERY OR CREMATORY LORRAINE PARK		22d. LOCATION (City, town, or county) WOODSLAWN MD	
23. FUNERAL DIRECTOR'S SIGNATURE GEO H LEIMBACH		ADDRESS 525 N LYNCHURST ST	
24a. REC'D BY REGISTRAR DATE 2-13-57		24b. REGISTRAR'S SIGNATURE L. J. Schlar	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH-BATHING
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex	
Place of Birth		Date of Birth		Date of Death	
Cause of Death		Manner of Death		Occupation	
Residence		City		County	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
Date		Time		Place	

BUREAU V. 2

1057

RECEIVED

1365

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>20 South Cherry Grove Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>W.</u> Last <u>Hurlock</u>		4. DATE OF DEATH Month <u>2</u> - Day <u>9</u> - Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-6-1872</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>	
11. BIRTHPLACE (State or foreign country) <u>Calvert Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James H. Jones</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Wood</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs Leo D. Miller</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Azotemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis generalized</u> (c) <u>Arthritis - Rheumatoid</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>5 yrs.</u> <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 10, 1948</u> to <u>Feb 9, 1957</u> , that I last saw the deceased alive on <u>Feb 9, 1957</u> , and that death occurred at <u>1:05 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James R. Martin</u> M.D.		ADDRESS (Street, city or town, state) <u>6 SHAW ST. ANNAPOLIS, MD.</u>	
PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>		DATE SIGNED <u>2/11/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-12-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>		24a. REC'D BY REGISTRAR <u>DATE</u>	
ADDRESS <u>Annapolis Md.</u>		24b. REGISTRAR'S SIGNATURE <u>J. J. [illegible]</u>	

RECEIVED

1957

REVIEWS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 FilmG212 3-18-57 et

01398

1408

CERTIFICATE OF DEATH

Reg. Dist. No.

28

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brownsville State Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>WESLEY</u> Last <u>ISAACS</u>				4. DATE OF DEATH Month <u>FEB</u> Day <u>3</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-6-1881</u>	
9. AGE (In years last birthday) <u>88 1/2</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>14</u>		IF UNDER 24 HRS. Hours <u>14</u> Min. <u>14</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM LABOUR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Dorothy Isaacs Edgewater Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> <u>cardiovascular disease</u> DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) <u>Unknown</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>None</u> p. m. <u>9</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/13</u> , 19 <u>56</u> , to <u>2/3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2/3</u> , 19 <u>57</u> , and that death occurred at <u>5:00</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Chas G. Hardy</u> M.D. <u>8913 GEORGIA AVE</u>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>CYRIL G. HARDY</u>				<u>SILVER SPRING Md</u>			
22a. BURIAL; CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-6-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chesw Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Owensville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Reese II</u> ADDRESS				24a. REC'D BY REGISTRAR <u>FEB 4 1957</u>		24b. REGISTRAR'S SIGNATURE <u>R. M. Joyce</u>	

BUREAU V. S.

FEB 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film G211, 3/7/57 bh

01399

1366

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS Md		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 ANNAPOLIS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 41-LARKINS		d. STREET ADDRESS 41-LARKINS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Johnson Last Johnson		4. DATE OF DEATH Month 2 Day 18 Year 1957	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 68 yrs.
9. AGE (In years last birthday) 68		IF UNDER 1 YEAR Months 0 Days 18 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Junior		10b. KIND OF BUSINESS OR INDUSTRY School Junior	
11. BIRTHPLACE (State or foreign country) Davidsonville Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES JOHNSON		14. MOTHER'S MAIDEN NAME MATILDA SPATISS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT MASSIE JOHNSON		Address 41-LARKINS ST.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Intestinal Perforation by peptic ulcer Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiovascular disease Grade III DUE TO Cardiovascular disease Grade III (c) Cardiovascular disease Grade III		INTERVAL BETWEEN ONSET AND DEATH 11	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 0 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 18, 1957 to Feb 18, 1957 , that I last saw the deceased alive on Feb 18, 1957 , and that death occurred at 8:11 M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 41-Larkins St. Annapolis, Md.	
ACTUAL SIGNATURE Ethel Hick M.D.		DATE SIGNED 3/20/57	
PHYSICIAN'S NAME (Type) Ethel Hick			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/21/57	
22c. NAME OF CEMETERY OR CREMATORY BREW HILL		22d. LOCATION (City, town, or county) (State) ANNAPOLIS Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ethel Hick 43 Northwest Annapolis Md.		24a. REC'D BY REGISTRAR DATE 3/20/57	
24b. REGISTRAR'S SIGNATURE John J. Lenchy			

CERTIFICATE OF DEATH

388

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. DATE OF DEATH [Faint text]</p>	
<p>7. CAUSE OF DEATH [Faint text]</p>		<p>8. MANNER OF DEATH [Faint text]</p>	
<p>9. SIGNATURE OF DECEASED [Faint text]</p>		<p>10. SIGNATURE OF WITNESSES [Faint text]</p>	
<p>11. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>12. SIGNATURE OF CORONER [Faint text]</p>	
<p>13. SIGNATURE OF JURY [Faint text]</p>		<p>14. SIGNATURE OF JUDGE [Faint text]</p>	
<p>15. SIGNATURE OF CLERK [Faint text]</p>		<p>16. SIGNATURE OF NOTARY [Faint text]</p>	

BUREAU V. S.

FEB 21 1957

RECEIVED

1367

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Wardour</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General</u>		d. STREET ADDRESS <u>1113 Wardour Drive</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Raymond Henry Lacey</u>		4. DATE OF DEATH Month Day Year <u>February 8 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 27, 1876</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Professor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Education</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry W. Lacey</u>		14. MOTHER'S MAIDEN NAME <u>Olive Durand</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Douglas Lacey</u>		Address <u># 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar pneumonia</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Vascular accident</u> DUE TO (c) <u>Generalized arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1955</u> to <u>2/8</u> , 1957, that I last saw the deceased alive on <u>2/8</u> , 1957, and that death occurred at <u>3:30</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank M. Shipley</u>		ADDRESS (Street, city or town, state) <u>63 College Ave</u> DATE SIGNED <u>2/10/57</u>	
PHYSICIAN'S NAME (Type) <u>Frank M. Shipley</u>		<u>Annapolis, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>2-11-57</u>	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) <u>Lanham, Pa</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Saylor</u>		ADDRESS <u>Sussex, Annapolis Md</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>V. Ormick</u>	
DATE			

CERTIFICATE OF DEATH

1957

PART OF DEATH NAME OF DECEASED JAMES H. JONES SEX MALE DATE OF BIRTH JANUARY 1, 1912 PLACE OF BIRTH BALTIMORE, MARYLAND RACE WHITE OCCUPATION LABORER MARITAL STATUS SINGLE RELIGION METHODIST USUAL RESIDENCE 1234 BALTIMORE STREET, BALTIMORE, MARYLAND DATE OF DEATH JANUARY 15, 1957 PLACE OF DEATH BALTIMORE, MARYLAND CAUSE OF DEATH HEART DISEASE MANNER OF DEATH NATURAL SIGNATURE OF PHYSICIAN J. H. JONES SIGNATURE OF REGISTRAR J. H. JONES OFFICIAL SEAL BALTIMORE, MARYLAND JANUARY 15, 1957		PART OF DEATH NAME OF DECEASED JAMES H. JONES SEX MALE DATE OF BIRTH JANUARY 1, 1912 PLACE OF BIRTH BALTIMORE, MARYLAND RACE WHITE OCCUPATION LABORER MARITAL STATUS SINGLE RELIGION METHODIST USUAL RESIDENCE 1234 BALTIMORE STREET, BALTIMORE, MARYLAND DATE OF DEATH JANUARY 15, 1957 PLACE OF DEATH BALTIMORE, MARYLAND CAUSE OF DEATH HEART DISEASE MANNER OF DEATH NATURAL SIGNATURE OF PHYSICIAN J. H. JONES SIGNATURE OF REGISTRAR J. H. JONES OFFICIAL SEAL BALTIMORE, MARYLAND JANUARY 15, 1957
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BUREAU V. 2

1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										01401
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND										2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pines on the Severn</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>U. S. General Hospital</i>										d. STREET ADDRESS <i>x 2 1</i>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) First <i>Scott</i> Middle <i>W.</i> Last <i>Lafferty</i>										4. DATE OF DEATH Month <i>2</i> Day <i>23</i> Year <i>1957</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Jan 25 - 1957</i>		9. AGE (In years last birthday) <i>4 weeks</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Annapolis Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>				
13. FATHER'S NAME <i>Frank H. Lafferty</i>					14. MOTHER'S MAIDEN NAME <i>Jean Whitlock</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>					16. SOCIAL SECURITY NO. <i>Same as 13 - 2</i>		17. INFORMANT <i>Same as 13 - 2</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>763.0</i> DUE TO <i>Bronchopneumonia</i> Conditions, if any, which gave rise to immediate cause (b) <i>Underlying</i> DUE TO <i>Underlying</i> (a), stating the underlying cause last. (c) <i>Sudden</i>										INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <i>Chunbaek</i>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED <i>2/13/57</i>
EXAMINER'S NAME (Type) <i>E. LINHARDT</i>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			22b. DATE THEREOF <i>2-25-57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Bellevue Memorial</i>			22d. LOCATION (City, town, or county) (State) <i>Annapolis Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>					ADDRESS <i>Annapolis Md</i>		24a. REC'D BY REGISTRAR <i>FEB 25 1957</i>		24b. REGISTRAR'S SIGNATURE <i>V. Brunch</i>	

2063323XV5

STATE DEPARTMENT OF HEALTH - BIRMINGHAM
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3.

FEB 27 1957

RECEIVED

1409

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

27

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum Heights c. LENGTH OF STAY IN 1b Few seconds d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 170		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY A.A. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Meade d. STREET ADDRESS Home address: 424 Swale Ave. Baltimore, Md. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last John Linwood Lewis		4. DATE OF DEATH Month Day Year February 16th. 19 57	
5. SEX M.	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/4/27
9. AGE (In years last birthday) 29 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier in the U.S. Army		10b. KIND OF BUSINESS OR INDUSTRY Nattaway Co, VA	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John B. Lewis		14. MOTHER'S MAIDEN NAME Gladys May	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) In the army at present.		16. SOCIAL SECURITY NO. 228-28-5527	
17. INFORMANT Fort Meade Records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of skull 823X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Automobile skidded on route 170			INTERVAL BETWEEN ONSET AND DEATH Sudden
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile skidded on route 170	
20c. TIME OF INJURY Month, Day, Year 6.15 a.m. 2/16/57 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 170	20f. (City or town) (County) (State) Linthicum Heights, A.A. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Gustave H. Faubert</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Gustave H. Faubert M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 20 Feb 57	
22c. NAME OF CEMETERY OR CREMATORY LEWIS (FAMILY) CEMETARY		22d. LOCATION (City, town, or county) (State) CREWE, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles R. Law</i> CHARLES R. LAW		24a. REC'D BY REGISTRAR W.L.SAYLOR, 1/Lt MSC	
ADDRESS 802 Madison Ave, Balti 1, Md		DATE 19 Feb 57	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the funeral director prior to burial, cremation, or removal.

100

FEB 21 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

014034

Items 8,9,16: G210 2-20-57L CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Balto City</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>118 Wilson Bldg. S.W.</i>		d. STREET ADDRESS <i>1432 Carroll St</i>	
3. NAME OF DECEASED (Type or print) First <i>MICHAEL</i> Middle <i>LITZ</i> Last		4. DATE OF DEATH Month <i>FEB.</i> Day <i>12th</i> Year <i>1957</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 20 1888</i>
9. AGE (In years last birthday) <i>68</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Furniture Finisher</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Furniture</i>	
11. BIRTHPLACE (State or foreign country) <i>Balto, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>yr. USA</i>	
13. FATHER'S NAME <i>unknown</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>212 05 7754</i>	
17. INFORMANT Address <i>Mrs Marg Riley (daughter) 118 Wilson Bldg SW Glen Burnie</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute myocardial infarction</i> DUE TO <i>arteriosclerotic Heart disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>420.0</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>1 day 4 yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Previous myocardial attack 6 mos ago.</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>no injury.</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to <i>12 Feb</i> , 19 <i>57</i> , that I last saw the deceased alive on _____, 19____, and that death occurred at <i>2:15 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>H.F. Manuzak</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>901 Edgerly Rd, Glen Burnie, Md. 12 Feb 57</i>	
PHYSICIAN'S NAME (Type) <i>H.F. MANUZAK</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Feb 15, 1957</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven</i>	22d. LOCATION (City, town, or county) (State) <i>Glen Burnie Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. S. Sington</i> ADDRESS <i>Glen Burnie, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>Feb 14, 1957</i>	24b. REGISTRAR'S SIGNATURE <i>L J DeAlba</i>

Note: Patient of Dr. Charles Mac Donnell. Mrs. Donnell's son called when Dr. Mac was not available. Patient was under Dr. Mac's care for some time. Dr. Mac was not available.

W. J. AND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

RECEIVED

1411

CERTIFICATE OF DEATH

Reg. Dist. No.

25

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel Co.</u> <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>50 Brooklyn</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>713 Church Street</u>				d. STREET ADDRESS <u>1529 Elmtree St.</u>			
3. NAME OF DECEASED (Type or print) First <u>MRS Antonia</u> Middle <u>LUBAK</u> Last <u>LUBAK</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>24</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April</u> , 1887	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Poland</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>	
13. FATHER'S NAME <u>Joseph Kosnik</u>				14. MOTHER'S MAIDEN NAME <u>Eva Pryztulska</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Family</u> Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adeno Carcinoma of Colon</u> <u>153X</u> DUE TO <u>with metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>Sept 9th, 1955</u> , to <u>Feb 24, 1957</u> , that I last saw the deceased alive on <u>Feb 24th, 1957</u> , and that death occurred at <u>12:10 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>Wm Conway</u>				M.D. <u>5301 Har</u>			
PHYSICIAN'S NAME (Type) <u> </u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/27/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>		22d. LOCATION (City, town, or county) (State) <u>Brooklyn, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Homes</u>				ADDRESS <u>130 E. Fort Ave.</u>		24a. REC'D BY REGISTRAR <u>Feb 26 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Ada Whitson</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED JOHN J. ROY		2. SEX MALE		3. AGE 68	
4. DATE OF DEATH FEB 26 1957		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH HOME	
7. STREET ADDRESS 1234 E. BALTIMORE ST.		8. CITY BALTIMORE		9. STATE MD.	
10. COUNTY JOHNS HOPKINS		11. ZIP CODE 21201		12. MARRIAGE STATUS MARRIED	
13. OCCUPATION RETIRED		14. CAUSE OF DEATH HEART DISEASE		15. MANNER OF DEATH NATURAL	
16. SIGNATURE OF PHYSICIAN [Signature]		17. SIGNATURE OF DECEASED [Signature]		18. SIGNATURE OF WITNESS [Signature]	
19. SIGNATURE OF REGISTRAR [Signature]		20. SIGNATURE OF CLERK [Signature]		21. SIGNATURE OF JUDGE [Signature]	

BUREAU V. 2

FEB 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01405

1412

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>aa</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>aa</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x1 Edgewater</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Winfield</u> Middle <u>Scott</u> Last <u>Lyons Sr.</u>		4. DATE OF DEATH Month <u>2</u> - Day <u>16</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 28-1880</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer Lobacco</u>	
11. BIRTHPLACE (State or foreign country) <u>West River Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William F. Lyons</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Peake</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Winfield S. Lyons Jr.</u>		Address <u>Edgewater Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis Generalized</u> DUE TO (c) <u>Pulmonary Emphysema</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>2 yrs.</u> <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 14</u> , 19 <u>50</u> , to <u>Feb. 16</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2-16-</u> 19 <u>57</u> , and that death occurred at <u>2:25</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6 SHAW ST. ANNAPOLIS, MD</u> DATE SIGNED <u>2/17/57</u>			
ACTUAL SIGNATURE <u>James R. Martin</u>		M.D. <u>ANNAPOLIS, MD</u>	
PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-19-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Marys</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Saylor Sons</u>		ADDRESS <u>Annapolis Md</u>	
24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

1369

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <u>63 Anne Arundel General</u>		d. STREET ADDRESS <u>116 Charles St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Rosaria</u> Middle <u>Ma</u> Last <u>9910</u>		4. DATE OF DEATH Month <u>February</u> Day <u>25</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 7th 1872</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Antonio CITRAVO</u>		14. MOTHER'S MAIDEN NAME <u>AGNESE MICELI</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Anthony J. Ma9910</u>	
17. INFORMANT Address <u>#2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>180x Carcinoma of Kidney</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (b) _____			INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 1952</u> to <u>Feb 25, 1957</u> , that I last saw the deceased alive on <u>Feb 24, 1957</u> , and that death occurred at <u>2 15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James R. Martin</u> M.D.		DATE SIGNED <u>2/25/57</u>	
PHYSICIAN'S NAME (Type) <u>DAMES R. MARTIN</u>		ADDRESS <u>6 Shaw St. Annapolis, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-27-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u> ADDRESS <u>Annapolis, Md.</u>		24. REC'D BY REGISTRAR <u>Feb 26 1957</u> 25. REGISTRAR'S SIGNATURE <u>J. O. [illegible]</u>	

CERTIFICATE OF DEATH

1957

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Reg. No. 10

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. DATE OF DEATH [Faint text]</p>	
<p>7. TIME OF DEATH [Faint text]</p>		<p>8. PLACE OF DEATH [Faint text]</p>	
<p>9. CAUSE OF DEATH [Faint text]</p>		<p>10. MANNER OF DEATH [Faint text]</p>	
<p>11. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>12. SIGNATURE OF REGISTRAR [Faint text]</p>	
<p>13. SIGNATURE OF WITNESS [Faint text]</p>		<p>14. SIGNATURE OF DECEASED [Faint text]</p>	

BUREAU V. R.

FEB 27 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1370

CERTIFICATE OF DEATH

Reg. Dist. No. 014021

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>C. C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. C. General Hosp.</u>		d. STREET ADDRESS <u>408 Chester Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Brenda</u> Middle <u>Ann</u> Last <u>Markell</u>		4. DATE OF DEATH Month <u>2</u> Day <u>26</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-1-56</u>
9. AGE (In years last birthday) yrs. <u>4</u>		IF UNDER 1 YEAR: Months <u>4</u> Days <u>26</u> Hours <u>15</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>John Albert Markell Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Betty S. Grant</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>John Albert Markell Jr.</u>		Address <u>Annapolis, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>493X</u> DUE TO <u>pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>cerebral anoxia</u> (c) <u>heart failure</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>heart failure</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 17, 1957</u> to <u>Feb 25, 1957</u> , that I last saw the deceased alive on <u>Feb 25, 1957</u> , and that death occurred at <u>midnight</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Nel H Sims</u>		ADDRESS (Street, city or town, state) <u>Annapolis, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>NEL H. SIMS</u>		DATE SIGNED <u>Feb 28, 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-1-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Annapolis Natl.</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese Jr.</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u>2-28-57</u>		24b. REGISTRAR'S SIGNATURE <u>John J. Bruck</u>	

CERTIFICATE OF DEATH

1870

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIED		OCCUPATION		EDUCATION		SCHOOLING		SPECIAL INSTRUCTIONS	
John Doe		45		Male		White		Roman Catholic		Married		Farmer		High School		None		None	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DURATION OF ILLNESS		PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS DRUGS		PREVIOUS TREATMENT	
Feb 28, 1957		Home		Heart Disease		Natural		2 weeks		None		None		None		None		None	
DATE OF BIRTH		PLACE OF BIRTH		CAUSE OF BIRTH		MANNER OF BIRTH		DURATION OF PREGNANCY		PREVIOUS PREGNANCY		PREVIOUS DELIVERY		PREVIOUS TRAUMA		PREVIOUS DRUGS		PREVIOUS TREATMENT	
Feb 28, 1912		Maryland		Normal		Natural		9 months		None		None		None		None		None	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DURATION OF ILLNESS		PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS DRUGS		PREVIOUS TREATMENT	
Feb 28, 1957		Home		Heart Disease		Natural		2 weeks		None		None		None		None		None	
DATE OF BIRTH		PLACE OF BIRTH		CAUSE OF BIRTH		MANNER OF BIRTH		DURATION OF PREGNANCY		PREVIOUS PREGNANCY		PREVIOUS DELIVERY		PREVIOUS TRAUMA		PREVIOUS DRUGS		PREVIOUS TREATMENT	
Feb 28, 1912		Maryland		Normal		Natural		9 months		None		None		None		None		None	

RECEIVED
FEB 28 1957
BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1371

CERTIFICATE OF DEATH

01408

Reg. Dist. No. " 21

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FERRIS Middle MC KNEW Last		4. DATE OF DEATH Month FEBRUARY Day 15 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 3, 1940
9. AGE (In years last birthday) 17 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY High School (3rd year)	
11. BIRTHPLACE (State or foreign country) Gotts, Station, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Roland W. McKnew		14. MOTHER'S MAIDEN NAME Ruth V. Downs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 213-36-3510	
17. INFORMANT Roland W. McKnew- Father- same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Staphylococcal septicemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 48 hrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/14 , 19 57 , to 2/15 , 19 57 , that I last saw the deceased alive on 2/15 , 19 57 , and that death occurred at 8:45 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 90 Cathedral Street, Annapolis, Md. DATE SIGNED 2/17/57			
ACTUAL SIGNATURE John H. Hedeman M.D.		DATE SIGNED 2/17/57	
PHYSICIAN'S NAME (Type) John Hedeman MD		ADDRESS 90 Cathedral Street, Annapolis, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-19-57	
22c. NAME OF CEMETERY OR CREMATORY Baldwin Memorial Cemetery Millersville, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME		24a. REC'D BY REGISTRAR Feb 19 1957	
ADDRESS ANNAPOLIS, MD.		24b. REGISTRAR'S SIGNATURE Am. J. French	

CERTIFICATE OF DEATH

1957

NAME OF DECEASED John DeLeon		SEX Male		RACE White		DATE OF BIRTH January 3, 1940		AGE 17		EDUCATION High School (7 years)		OCCUPATION Student		PLACE OF BIRTH Maryland		PLACE OF DEATH Johns Hopkins General Hospital	
DATE OF DEATH February 15, 1957		TIME OF DEATH 11:30 AM		CAUSE OF DEATH Sudden		MANNER OF DEATH Natural		PLACE OF DEATH Johns Hopkins General Hospital		DATE OF DEATH February 15, 1957		TIME OF DEATH 11:30 AM		CAUSE OF DEATH Sudden		MANNER OF DEATH Natural	
NAME OF DECEASED John DeLeon		SEX Male		RACE White		DATE OF BIRTH January 3, 1940		AGE 17		EDUCATION High School (7 years)		OCCUPATION Student		PLACE OF BIRTH Maryland		PLACE OF DEATH Johns Hopkins General Hospital	
DATE OF DEATH February 15, 1957		TIME OF DEATH 11:30 AM		CAUSE OF DEATH Sudden		MANNER OF DEATH Natural		PLACE OF DEATH Johns Hopkins General Hospital		DATE OF DEATH February 15, 1957		TIME OF DEATH 11:30 AM		CAUSE OF DEATH Sudden		MANNER OF DEATH Natural	

BUREAU V. 2

FEB 19 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01409

1372

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.</u>		d. STREET ADDRESS <u>107 Severn Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Baby Boy</u> Middle <u>McKOWN</u> Last <u>McKOWN</u>		4. DATE OF DEATH Month <u>February</u> Day <u>21</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-21-57</u>
9. AGE (In years lost birthday) yrs. <u>6</u>		IF UNDER 1 YEAR: Months <u>6</u> Days <u>6</u> Hours <u>6</u> Min. <u>6</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Elliott McKOWN</u>		14. MOTHER'S MAIDEN NAME <u>Alice Lenore LUCAS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>- -</u>	
17. INFORMANT <u>U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity with Immaturity</u> DUE TO 776 x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>21 FEB</u> , 19 <u>57</u> , to <u>21 FEB</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>21 FEB</u> , 19 <u>57</u> , and that death occurred at <u>2:05 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Richard D. Sheehan</u> M.D. <u>21 FEB 1957</u> PHYSICIAN'S NAME (Type) <u>RICHARD D. SHEEHAN LT MC USNR</u> <u>U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.</u>			
22a. BURIAL, CREMATION, or other disposal (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u> <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>U.S. NAVAL HOSPITAL</u> <u>25 FEB 1957</u>	

2051244 XVI

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Signature of witness		12. Signature of coroner	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery		16. Signature of burial place	
17. Signature of burial place		18. Signature of burial place		19. Signature of burial place		20. Signature of burial place	
21. Signature of burial place		22. Signature of burial place		23. Signature of burial place		24. Signature of burial place	
25. Signature of burial place		26. Signature of burial place		27. Signature of burial place		28. Signature of burial place	
29. Signature of burial place		30. Signature of burial place		31. Signature of burial place		32. Signature of burial place	
33. Signature of burial place		34. Signature of burial place		35. Signature of burial place		36. Signature of burial place	
37. Signature of burial place		38. Signature of burial place		39. Signature of burial place		40. Signature of burial place	
41. Signature of burial place		42. Signature of burial place		43. Signature of burial place		44. Signature of burial place	
45. Signature of burial place		46. Signature of burial place		47. Signature of burial place		48. Signature of burial place	
49. Signature of burial place		50. Signature of burial place		51. Signature of burial place		52. Signature of burial place	
53. Signature of burial place		54. Signature of burial place		55. Signature of burial place		56. Signature of burial place	
57. Signature of burial place		58. Signature of burial place		59. Signature of burial place		60. Signature of burial place	
61. Signature of burial place		62. Signature of burial place		63. Signature of burial place		64. Signature of burial place	
65. Signature of burial place		66. Signature of burial place		67. Signature of burial place		68. Signature of burial place	
69. Signature of burial place		70. Signature of burial place		71. Signature of burial place		72. Signature of burial place	
73. Signature of burial place		74. Signature of burial place		75. Signature of burial place		76. Signature of burial place	
77. Signature of burial place		78. Signature of burial place		79. Signature of burial place		80. Signature of burial place	
81. Signature of burial place		82. Signature of burial place		83. Signature of burial place		84. Signature of burial place	
85. Signature of burial place		86. Signature of burial place		87. Signature of burial place		88. Signature of burial place	
89. Signature of burial place		90. Signature of burial place		91. Signature of burial place		92. Signature of burial place	
93. Signature of burial place		94. Signature of burial place		95. Signature of burial place		96. Signature of burial place	
97. Signature of burial place		98. Signature of burial place		99. Signature of burial place		100. Signature of burial place	

BUREAU V. S.

FEB 27 1957

RECEIVED

CERTIFICATE OF DEATH

1957

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
SEX		RACE		EDUCATION	
MARRIAGE		OCCUPATION		CAUSE OF DEATH	
DATE OF DEATH		PLACE OF DEATH		MANNER OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. 2

1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01411

1414

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>		c. LENGTH OF STAY IN 1b <u>25 yrs X 25</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park MD.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Dividing Rd. Manhattan Beach</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Brooks Mellor</u>		4. DATE OF DEATH <u>2</u> <u>16</u> <u>1957</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 4, 1880</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR: Months <u>76</u> Days <u>76</u> Hours <u>76</u> Min. <u>76</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate Broker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>	
11. BIRTHPLACE (State or foreign country) <u>Sykesville</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Edwin M. McElroy</u>		14. MOTHER'S MAIDEN NAME <u>Mary W. Lemmen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>	
17. INFORMANT <u>Mrs. Rose Bachman</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>Emphysema-Bronchiectasis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1955</u> , 19 <u>57</u> , to <u>2-15 Feb</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2-15-57</u> , 19 <u>57</u> , and that death occurred at <u>2:14 A.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. Hahn</u> M.D.		ADDRESS (Street, city or town, state) <u>Severna Park Md 2-16-57</u>	
PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>		DATE SIGNED <u>2-16-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/18/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Springfield Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Sykesville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. G. Tucker</u> ADDRESS <u>1000 North H.A. Ave.</u>		24a. REC'D BY REGISTRAR <u>Feb. 18, 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>L. J. Dealy</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

BUREAU V. S.

FEB 19 1957

RECEIVED

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
DATE OF BIRTH [Illegible]		PLACE OF BIRTH [Illegible]		RACE [Illegible]	
DATE OF DEATH [Illegible]		PLACE OF DEATH [Illegible]		CAUSE OF DEATH [Illegible]	
TIME OF DEATH [Illegible]		MANNER OF DEATH [Illegible]		SIGNATURE OF DECEASED [Illegible]	
SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF CORONER [Illegible]	
SIGNATURE OF JUDGE [Illegible]		SIGNATURE OF CLERK [Illegible]		SIGNATURE OF REGISTRAR [Illegible]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01412

1373

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NO PASADENA</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HOMERWOOD NURSING HOME</u>				e. STREET ADDRESS <u>1 BODKIN CREEK</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>PAUL</u> Middle <u>MILLER</u> Last <u></u>				4. DATE OF DEATH Month <u>FEB.</u> Day <u>3</u> Year <u>1957</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB. 18, 1867</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATER MAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CRABBIN</u>		11. BIRTHPLACE (State or foreign country) <u>BAVARIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>IRVING T. JOHNSON</u> Address <u>RIVIERA BEACH</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1. INANITION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>1999</u> (b) <u>METASTATIC BASAL CELL CARCINOMA</u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 WKS.</u> <u>1 YEAR</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4221</u> <u>ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>3 FEB</u> , 19 <u>57</u> , to <u>3 FEB</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3 FEB</u> , 19 <u>57</u> , and that death occurred at <u>10:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward S. Beck</u> M.D. <u>44 Southgate Ave</u>				ADDRESS (Street, city or town, state) <u>Annapolis Maryland</u>			
DATE SIGNED <u>3 Feb 1957</u>							
PHYSICIAN'S NAME (Type) <u>Edward S. Beck</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>FEB. 6, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HOLY CROSS CEM</u>		22d. LOCATION (City, town, or county) (State) <u>RITCHIE HWY A.A.G., MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Goren</u> ADDRESS <u>4601 Ritchie Hwy</u>				24a. REC'D BY REGISTRAR <u>DATE 2-6-57</u>		24b. REGISTRAR'S SIGNATURE <u>Jim J. Zisch</u>	

220

BUREAU V. S.

FEB 7 1968

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1415

CERTIFICATE OF DEATH

01413

Reg. Dist. No.

28

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville	c. LENGTH OF STAY IN 1b 1 day	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Severn	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. STREET ADDRESS 1 Not given	f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Walter Middle Mosley Last Mosley		4. DATE OF DEATH Month 2 Day 27 Year 1957	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 7 Days 13 Hours 13 Min.	IF UNDER 24 HRS. Hours 13 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Gravel Pit	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME Clem Mosley	
14. MOTHER'S MAIDEN NAME Amy Richardson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Mrs. Jessie Davis, daughter 205 E. 11th St., Wilmington, Delaware	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 450.0 DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cancer of prostate gland		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 2/26 , 1957 , to 2/27 , 1957 , that I last saw the deceased alive on 2/26 , 1957 , and that death occurred at 4:15 a.m. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Lionel McHenry Mapp M.D.		ADDRESS (Street, city or town, state) Crownsville, Md.	
DATE SIGNED 2/27/57			
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-2-57	22c. NAME OF CEMETERY OR CREMATORY Brewer Hill	22d. LOCATION (City, town, or county) (State) Annapolis Md.
23. FUNERAL DIRECTOR'S SIGNATURE William Dese, Jr.		ADDRESS Annapolis, Md.	
24a. REC'D BY REGISTRAR 2-28-57		24b. REGISTRAR'S SIGNATURE R. M. Joyce	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
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the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01414

1374 CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Naval Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>Law</u> Last <u>Nass</u>		4. DATE OF DEATH Month <u>February</u> Day <u>22</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-10-36 85</u>
9. AGE (In years last birthday) <u>71 79</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - -</u>	
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Gottlob Heinrich Seidle</u>		14. MOTHER'S MAIDEN NAME <u>Mina Caroline Schifferer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>John Nass</u>		Address <u>4 Ferndale Road, Ferndale, Glen Burnie, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Abscess with Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Carcinoma of Brain, Lung, and Liver</u> DUE TO (c) <u>Carcinoma of Breast (Right)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 year</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>17 February, 19 57</u> to <u>22 February, 19 57</u> , that I last saw the deceased alive on <u>22 February, 19 57</u> , and that death occurred at <u>3:00 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Vincent P. Butler, Jr.</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>U. S. Naval Hospital</u> <u>2/22/57</u>	
PHYSICIAN'S NAME (Type) <u>Vincent P. Butler, Jr.</u>		<u>Annapolis, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 25-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Silverbrook Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Wilmington, Del.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. L. Singleton</u>		ADDRESS <u>Glen Burnie</u>	
24. REC'D BY REGISTRAR <u>B 27 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. J. French</u>	

FEB 27 1957

BUREAU V. S.

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01415

1416

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>C. C.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Edgewater</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x15 Edgewater</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>1</i>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Sarah Jane Neal</i>		4. DATE OF DEATH Month <i>2</i> Day <i>27</i> Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Cauc</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-15-1881</i>
9. AGE (In years last birthday) <i>75</i> yrs.		IF UNDER 1 YEAR: Months <i>75</i> Days <i>75</i> Hours <i>75</i> Min. <i>75</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Richard Boston</i>		14. MOTHER'S MAIDEN NAME <i>Dorothy Watkins</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>14</i>	
17. INFORMANT <i>Mary Layman Edgewater</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>5-24-56</i> , 19____, to <i>2-27-57</i> , 19____, that I last saw the deceased alive on <i>2-22-57</i> , 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>AT Allen</i>		ADDRESS (Street, city or town, state) <i>62 Calverton St</i> DATE SIGNED <i>3-2-57</i>	
PHYSICIAN'S NAME (Type) <i>AT ALLEN</i>		<i>Ameyob and</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-2-57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Chews Chapel</i>		22d. LOCATION (City, town, or county) (State) <i>Owensville Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Base, Jr. Annapolis, Md.</i>		ADDRESS	
24a. REC'D BY REGISTRAR <i>4</i>		24b. REGISTRAR'S SIGNATURE <i>Am J. French</i>	

BUREAU V. 2

MAR 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01416

Items 8,9: G 211 2 20-57 L **CERTIFICATE OF DEATH**

Reg. Dist. No. *14*

1. PLACE OF DEATH a. COUNTY A.A. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY A.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sunset Beach		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sunset Beach	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) PATRICIA ANN NOLAN		4. DATE OF DEATH 2/1/57	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/30/55 56
9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR Months 2 Days 3 Hours 5 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland Balto. City		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Thomas		14. MOTHER'S MAIDEN NAME Margaret Squires	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Family - Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from January 31, 1957 to Feb 1, 1957 , that I last saw the deceased alive on January 31, 1957 , and that death occurred at 6:00 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE R.M. McLaughlin		ADDRESS (Street, city or town, state) REF 8 Box 442 Pasadena Feb 1, 1957	
PHYSICIAN'S NAME (Type) R.M. McLaughlin		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) B	22b. DATE THEREOF 2/4/57	22c. NAME OF CEMETERY OR CREMATORY Holy Cross	22d. LOCATION (City, town, or county) (State) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes - 130 E. Fort Ave.		24a. REC'D BY REGISTRAR FEB 1 1957 24b. REGISTRAR'S SIGNATURE L. J. Schley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2046321 XV 5

BUREAU V. S.

FEB 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1375 CERTIFICATE OF DEATH

01417

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>A. A.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>A. A.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>xo Arth. Station</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>U. C. General</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Della Mae North</i>				4. DATE OF DEATH <i>2 - 1 - 19 57</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-24-1882</i>		9. AGE (In years last birthday) <i>74</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Benwood West Va</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Jacob Strober</i>				14. MOTHER'S MAIDEN NAME <i>Emma Marshall</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>-</i>		16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Charles H. North</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>uremia</i> <i>442X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>arteriosclerotic cardio-vascular renal disease</i> DUE TO (c) <i>-</i>							INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>cirrhosis of liver</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May 1943</i> , 19____, to <i>Feb. 1</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>Feb. 1</i> , 19 <i>57</i> , and that death occurred at <i>1:50A</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <i>S. Borasuck</i> M.D.				ADDRESS <i>Amos Garrett Blvd., Annapolis, Md.</i> DATE SIGNED <i>2/3/57</i>			
PHYSICIAN'S NAME (Type) <i>S. Borasuck, M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2-4-57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>London Park</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i> ADDRESS <i>Annapolis Md</i>				24a. REC'D. BY REGISTRAR DATE <i>2/5/57</i>		24b. REGISTRAR'S SIGNATURE <i>- U. Ormick</i>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
JAMES EARL RAY		M		35		JAN 19 1928		MEMPHIS, TENN		LABORER		SINGLE		WHITE	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF REGISTRAR		16. SIGNATURE OF WITNESSES	
FEB 4 1968		11:00 AM		MEMPHIS, TENN		HEART DISEASE		NATURAL		[Signature]		[Signature]		[Signature]	
17. COUNTY		18. CITY		19. STATE		20. ZIP CODE		21. COUNTY		22. CITY		23. STATE		24. ZIP CODE	
MEMPHIS		MEMPHIS		TENN		38102		MEMPHIS		MEMPHIS		TENN		38102	
25. COUNTY		26. CITY		27. STATE		28. ZIP CODE		29. COUNTY		30. CITY		31. STATE		32. ZIP CODE	
MEMPHIS		MEMPHIS		TENN		38102		MEMPHIS		MEMPHIS		TENN		38102	

BUREAU V. 2

FEB 7 1968

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 1
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1376

CERTIFICATE OF DEATH

01418

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>aa</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>aa</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>10</u> <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>619 Severn Ave</u>		d. STREET ADDRESS <u>619 Severn Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Adalbert J.</u> Middle <u>Oktauec</u> Last <u>Oktauec</u>		4. DATE OF DEATH Month <u>2</u> - Day <u>28</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-14-1880</u>
9. AGE (In years last birthday) yrs. <u>76</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TOOL MAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Govt. Ret.</u>	
11. BIRTHPLACE (State or foreign country) <u>CZECHOSLOVAKIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>JOHN OKTAVEC</u>		14. MOTHER'S MAIDEN NAME <u>MARY BLAKA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>AGNES M. OKTAVEC</u>		Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure - Pulmonary Edema</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>UNKNOWN</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1 Jan.</u> , 1957, to <u>28 FEB.</u> , 1957, that I last saw the deceased alive on <u>28 FEB.</u> , 1957, and that death occurred at <u>8:50 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>41 Southgate Ave</u> DATE SIGNED <u>3/1/57</u> ACTUAL SIGNATURE <u>Edward S. Beck</u> M.D. <u>ANNAPOLIS, MARYLAND</u> PHYSICIAN'S NAME (Type) <u>EDWARD S. BECK MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-2-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Marys</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Laylor Sns</u>		24a. REC'D BY REGISTRAR <u>U. Branch</u>	
ADDRESS <u>Annapolis md</u>		24b. REGISTRAR'S SIGNATURE <u>U. Branch</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE	
JOHN O'NEAL		45		M		W	
RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
100 N. ST.		MAY 10 1957		HOSPITAL		HEART DISEASE	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION	
LABORER		8		M		CATHOLIC	
BIRTH		DEATH		BURIAL		INTERVIEW	
MAY 10 1957		MAY 10 1957		MAY 10 1957		MAY 10 1957	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
[Signature]		[Signature]		[Signature]		[Signature]	
DATE		TIME		PLACE		CAUSE	
MAY 10 1957		10:00 AM		HOSPITAL		HEART DISEASE	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
[Signature]		[Signature]		[Signature]		[Signature]	
DATE		TIME		PLACE		CAUSE	
MAY 10 1957		10:00 AM		HOSPITAL		HEART DISEASE	

BUREAU V. 8

MAR 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1377

CERTIFICATE OF DEATH

Reg. Dist. No.

01419

21

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>D.C.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 16	
3. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A. A. General Hosp.</i>		d. STREET ADDRESS <i>Davidsonville</i>	
4. NAME OF DECEASED (Type or print) First Middle Last <i>Galloway Parker</i>		4. DATE OF DEATH Month <i>2</i> Day <i>20</i> Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-1-1893</i>
9. AGE (In years last birthday) <i>63</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farm</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Self</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Nelson Parker</i>		14. MOTHER'S MAIDEN NAME <i>Bobbie Parker</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, how or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-30-3013</i>	
17. INFORMANT <i>Lucy Parker-Davidsonville</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiovascular accident</i> 381X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Severe hypertension</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>7 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>2/18</i> , 19 <i>57</i> to <i>2/20</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>2/20</i> , 19 <i>57</i> , and that death occurred at <i>8:45</i> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John C. Hildebrand</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>2/23/57</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2-25-57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Adams Chapel</i>		22d. LOCATION (City, town, or county) (State) <i>Bayard, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, Jr. - Annapolis, Md.</i>		ADDRESS <i>240</i> REC'D BY REGISTRAR <i>245</i> REGISTRAR'S SIGNATURE <i>Am. J. French</i>	

CERTIFICATE OF DEATH

1957

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

For use in

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Manner of Death		Cause of Death		Date of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		1912		Maryland		Natural		Heart Disease		February 28, 1957		Baltimore		10:00 AM		J. Doe, M.D.		J. Doe, M.D.	
Occupation		Marital Status		Previous Illnesses		Last Medical Examination		Last Seen Alive		Buried or Not		Burial Place		Burial Date		Burial Time		Burial Place		Burial Time		Burial Place	
Teacher		Married		None		1956		1956		Yes		Catholic		1957		10:00 AM		Catholic		10:00 AM		Catholic	
Signature of Deceased		Signature of Spouse		Signature of Child		Signature of Parent		Signature of Sibling		Signature of Friend		Signature of Neighbor		Signature of Stranger		Signature of Other		Signature of Other		Signature of Other		Signature of Other	
None		None		None		None		None		None		None		None		None		None		None		None	

BUREAU V. 2

FEB 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove corban papers. Page 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1378

CERTIFICATE OF DEATH

01420
Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>C.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>15 Lee St.</u>		d. STREET ADDRESS <u>15 Lee St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle <u>Peters</u> Last <u>Peters</u>		4. DATE OF DEATH Month <u>2</u> Day <u>9</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-9-1892</u>
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min. <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>C.C. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George A. Peters</u>		14. MOTHER'S MAIDEN NAME <u>Ella Ford</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-28-0755</u>	
17. INFORMANT <u>Georgianna Peters</u>		Address <u>Annapolis Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hyper-tensive Cardiovascular Dis.</u> DUE TO (c) <u>4 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 30</u> , 19 <u>53</u> , to <u>Feb 9</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb 8</u> , 19 <u>57</u> , and that death occurred at <u>3:38</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jay W. Allen</u> M.D.		ADDRESS (Street, city or town, state) <u>62 Cathedral</u> DATE SIGNED <u>2-11-57</u>	
PHYSICIAN'S NAME (Type) <u>FAYE W. ALLEN</u>		<u>Annapolis Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>2-13-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fowler's Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>Best Gate Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr.</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u>Dr. Wm. French</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Wm. French</u>	

CERTIFICATE OF DEATH

1957

NAME: *Johnnie Lee*
AGE: *45*
SEX: *Male*
RACE: *White*
DATE OF BIRTH: *1912*
PLACE OF BIRTH: *St. Louis, Mo.*
OCCUPATION: *Teacher*
CAUSE OF DEATH: *Heart Disease*
DATE OF DEATH: *10-15-57*
PLACE OF DEATH: *Home*
SIGNATURE: *[Signature]*
DATE: *10-15-57*

NAME: *Johnnie Lee*
AGE: *45*
SEX: *Male*
RACE: *White*
DATE OF BIRTH: *1912*
PLACE OF BIRTH: *St. Louis, Mo.*
OCCUPATION: *Teacher*
CAUSE OF DEATH: *Heart Disease*
DATE OF DEATH: *10-15-57*
PLACE OF DEATH: *Home*
SIGNATURE: *[Signature]*
DATE: *10-15-57*

NAME: *Johnnie Lee*
AGE: *45*
SEX: *Male*
RACE: *White*
DATE OF BIRTH: *1912*
PLACE OF BIRTH: *St. Louis, Mo.*
OCCUPATION: *Teacher*
CAUSE OF DEATH: *Heart Disease*
DATE OF DEATH: *10-15-57*
PLACE OF DEATH: *Home*
SIGNATURE: *[Signature]*
DATE: *10-15-57*

BUREAU V. 2

3 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1418. CERTIFICATE OF DEATH

01421

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHALK PT. WEST RIVER, MD.</u>		c. LENGTH OF STAY IN 1b <u>60 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WILSON</u> First Middle Last		4. DATE OF DEATH <u>Feb. 2</u> 1957 Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 2 1871</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OYSTER + FARM</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>DEALE, MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>T. NICKALAS</u>		14. MOTHER'S MAIDEN NAME <u>LOUISE KIRCHNER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Louis N. Phipps 67 College Ave Annapolis MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4341 pneumonia, left upper lobe</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>congestive failure</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arterio sclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 2</u> , 19 <u>57</u> , to <u>Feb. 2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2 February</u> , 19 <u>57</u> , and that death occurred at <u>4:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>FDH Hendricks</u> M.D.		ADDRESS (Street, city or town, state) <u>Shady Side, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>FDH Hendricks</u>		DATE SIGNED <u>4 Feb 57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/4/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. James</u>	22d. LOCATION (City, town, or county) (State) <u>TRACYS RA Co Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>BERNARD Hardisty</u> ADDRESS <u>Edlesville Md.</u>		24a. REC'D BY REGISTRAR <u>U. D. Church</u> 24b. REGISTRAR'S SIGNATURE	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director.
TO REGISTRAR: This certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01422

1419

CERTIFICATE OF DEATH

Reg. Dist. No.

28

Crownsville

10

I

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 2mos. 18days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3v01-4		✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS 2605 Spellman Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Emma Middle Powell Last Powell		4. DATE OF DEATH Month 2 Day 28 Year 1957	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/12/03 ?
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY - - -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Not given		14. MOTHER'S MAIDEN NAME Mahalia Pinkett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk. (If yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT State Hospital		Crownsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 442X DUE TO Hypertensive cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardiovascular renal disease DUE TO (c) Hypertensive cardiovascular renal disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypostatic Pneumonia		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/27 , 19 57 , to 2/28 , 19 57 , that I last saw the deceased alive on 2/28 , 19 57 , and that death occurred at 11:15 a.m. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Lionel McHenry Mapp M.D.		ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 2/28/57	
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp			
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 3/4/57	
22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Geo. M. Kelson ADDRESS 1348 N. Calhoun St.		24a. REC'D BY REGISTRAR 3/5/57 24b. REGISTRAR'S SIGNATURE J. M. Jones	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION	
7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH	
10. MEDICAL HISTORY		11. HISTORY OF PRESENT ILLNESS		12. POST-MORTEM EXAMINATION	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF REGISTRAR	
16. DATE OF REGISTRATION		17. PLACE OF REGISTRATION		18. OFFICIAL SEAL	

BUREAU V. S.

MAR 6 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1420

CERTIFICATE OF DEATH

01423

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>D.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ORCHARD BEACH</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 ORCHARD BEACH</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7800 HIGH POINT ROAD</u>				d. STREET ADDRESS <u>7800 HIGH POINT RD.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALICE J. POWERS</u>				4. DATE OF DEATH Month Day Year <u>FEB. 25 1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 31, 1874</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>SAMUEL TAYLOR</u>				14. MOTHER'S MAIDEN NAME <u>ROSE GARVEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>JOSEPH S. TAYLOR 7800 HIGH PT. RD. AAG.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute pulmonary edema</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>—</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>7 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>cerebro-vascular accident - 1950</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>April 10, 1950</u> , to <u>Feb. 25, 1957</u> , that I last saw the deceased alive on <u>Feb. 24, 1957</u> , and that death occurred at <u>2:17 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. M. McLaughlin</u>				ADDRESS (Street, city or town, state) <u>Pasadena, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>R. M. McLaughlin</u>				DATE SIGNED <u>Feb. 25, 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>FEB 27, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL Cem.</u>	
22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Rouse</u>				ADDRESS <u>4001 RITCHIE Hwy</u>		24a. REC'D BY REGISTRAR <u>MAR 1 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>L. J. Gabel</u>							

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, cause of death, and place of death. The form is partially filled out with handwritten text.

BUREAU V. S.

MAR 1 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1421

CERTIFICATE OF DEATH

Reg. Dist. No. 142428

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 6rs.5mos.10days Baltimore City 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Miranda Middle Price Last Price		4. DATE OF DEATH Month 2 Day 10 Year 19 57	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/1/79
9. AGE (In years lost birthday) yrs. 77		IF UNDER 1 YEAR Months 7 Days 10 Hours 19 Min. 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - -	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Kane Jacobs		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Hospital Records		Address State Hospital Crownsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Arteriosclerotic cardiovascular-renal disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Dehydration, Malnutrition, Decubitus ulcers			
INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/10 , 19 57 , to 2/10 , 19 57 , that I last saw the deceased alive on 2/8 , 19 57 , and that death occurred at 2:30 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 2/10/57 ACTUAL SIGNATURE Lionel McHenry Mapp M.D. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) 2-14-57		22b. DATE THEREOF 2-14-57	
22c. NAME OF CEMETERY OR CREMATORY mt Cal.		22d. LOCATION (City, town, or county) (State) Brooklyn Md. acc.	
23. FUNERAL DIRECTOR'S SIGNATURE Ed. Wilson		ADDRESS 1000 Bandy av	
24a. REC'D BY REGISTRAR LB 13 1957		24b. REGISTRAR'S SIGNATURE K. M. Joyce	

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]		4. DATE OF BIRTH [Illegible]		5. PLACE OF BIRTH [Illegible]	
6. OCCUPATION [Illegible]		7. MARITAL STATUS [Illegible]		8. EDUCATION [Illegible]		9. RELIGION [Illegible]		10. RACE [Illegible]	
11. DATE OF DEATH [Illegible]		12. TIME OF DEATH [Illegible]		13. PLACE OF DEATH [Illegible]		14. CAUSE OF DEATH [Illegible]		15. MANNER OF DEATH [Illegible]	
16. SIGNATURE OF REGISTRAR [Illegible]		17. SIGNATURE OF DECEASED [Illegible]		18. SIGNATURE OF WITNESS [Illegible]		19. SIGNATURE OF PHYSICIAN [Illegible]		20. SIGNATURE OF CORONER [Illegible]	

RECEIVED
FEB 13 1957 J.A.
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01425

1379

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>10</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carvel Hall</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Pumphrey</u> Last <u>7</u>		4. DATE OF DEATH Month <u>2</u> Day <u>2</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-25-1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Reg nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Reg nurse</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Winter Pumphrey</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Friensien</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mrs. Henry E. Smith</u>		Address <u>Blandair Ellicott City, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>331X</u> (c), stating the underlying cause lost. DUE TO (c) <u>Stroke</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Stroke</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-5-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Saylor</u>		ADDRESS <u>Annapolis</u>	
24a. REC'D BY REGISTRAR <u>2/5/57</u>		24b. REGISTRAR'S SIGNATURE <u>V. V. V. V.</u>	

STATE OF NEW YORK
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF MEDICAL EXAMINER		DATE		PLACE		CITY		COUNTY		STATE	
SIGNATURE OF WITNESS		DATE		PLACE		CITY		COUNTY		STATE	

BUREAU V. S.

FEB 7 1957

RECEIVED

1

INSTRUCTIONS

TO THE ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01426

1422

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Burns - Glen Burnie</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Burns - Glen Burnie</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Burns - Glen Burnie</u>		LENGTH OF STAY (In this place) <u>77 yrs</u>		STREET ADDRESS (If rural give location) <u>Marley Station Rd. Glen Burnie, P.O.</u>		STREET ADDRESS (If rural give location) <u>Marley Station Rd. Glen Burnie, P.O.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Marley Station Rd. Glen Burnie</u>				HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Marley Station Rd. Glen Burnie</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Louis Edgar Pumphrey</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 10 1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>August 15, 1879</u>	9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>		11. BIRTHPLACE (State or foreign country) <u>Glen Burnie, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Osborne Stallings Pumphrey</u>				14. MOTHER'S MAIDEN NAME <u>Leandra Stump Robinson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT & ADDRESS <u>Anne Wilson Pumphrey - Same</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>420.1</u>		DUE TO <u>Respiratory Failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 MIN</u>			
ANTECEDENT CAUSE(S) (B) <u>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</u>		DUE TO <u>Congestive Heart Failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>			
STATING UNDERLYING CAUSE LAST, (C) <u>Coronary Occlusion</u>		DUE TO <u>Senility</u>		INTERVAL BETWEEN ONSET AND DEATH <u>25 days</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senility</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/22</u> , 19 <u>56</u> , to <u>2/10</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2/8</u> , 19 <u>57</u> , and that death occurred at <u>7:15 A.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Richard</u>				ADDRESS (Street, city, town, state) <u>715 Totten Rd. Glen Burnie, Md.</u>		DATE SIGNED <u>2/10/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>Feb. 13, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		LOCATION (City, town, or county) (State) <u>Brooklyn Rd., Md.</u>	
24. REC'D BY REGISTRAR <u>Feb 12, 1957</u>		REGISTRAR'S SIGNATURE <u>L. J. DeAlba</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. J. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>	

BUREAU V. S.

EB 13 1957

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1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01427

1423 CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Fort G. G. Meade</u>		<u>DOA</u>		TOWN <u>Fort George G. Meade</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1929 E. Reece Road</u>				STREET ADDRESS (If rural give location) <u>1929 E. Reece Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>WINIFRED</u> (Middle) <u>ANN</u> (Last) <u>BAU</u>				(Month) <u>6 February</u> (Day) <u>1957</u> (Year)			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>28 July 1921</u>	9. AGE last birthday <u>35 Yr</u> yrs.	IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Francis Murray</u>				14. MOTHER'S MAIDEN NAME <u>Alice Cecilia Nevins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Husband, 1929 E. Reece Road, Fort George G. Meade, Maryland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Coronary Occlusion</u>							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6 Feb 57</u> , to <u>6 Feb 57</u> , 19....., that I last saw the deceased alive on <u>6 Feb 57</u> , and that death occurred at <u>2:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>S. H. Tarabishy</u>		SAID H. TARABISHY, Maj, MC		ADDRESS (Street, city, town, state) <u>U. S. Army Hospital Fort Meade Md</u>		DATE SIGNED <u>6 Feb 57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>2-11-57</u>		NAME OF CEMETERY OR CREMATORY <u>Garlington</u>		LOCATION (city, town, or county) (State) <u>Wash DC</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>W. L. SKYLOR</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas S. Dorsett</u>		ADDRESS <u>WM COOK, INC, Baltimore, Maryland</u>	
DATE <u>7 Feb 57</u>		W. L. SKYLOR, 1ST LT, MSC.					

1992

BUREAU V. S.

FEB 11 1961

RECEIVED

1424

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 22 yrs. 1 mo. 15 da.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 900 Lake St., Extended			
3. NAME OF DECEASED (Type or print) First Dorothy Middle Robbins Last Robbins				4. DATE OF DEATH Month 2 Day 8 Year 1957			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/12/08	
9. AGE (In years last birthday) yrs. 49		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME Jack Dennis				14. MOTHER'S MAIDEN NAME Bessie Toadvine			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Unk.		17. INFORMANT Crownsville State Hosp. Hospital Records Crownsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Damage 422.1 DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1/25 , 19 48 , to 2/8 , 19 57 , that I last saw the deceased alive on 2/7 , 19 57 , and that death occurred at 3:45 a.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 2/8/57							
ACTUAL SIGNATURE Ludwig Benedict, M. D.				PHYSICIAN'S NAME (Type) Ludwig Benedict			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
2/11/57		2/11/57		Green Acres		Salisbury Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Stewart				24a. REC'D BY REGISTRAR DATE 2/10/57		24b. REGISTRAR'S SIGNATURE Katharine Joyce	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01429

1380

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>		d. STREET ADDRESS <u>45 Madison Place</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ANDREW</u> Middle <u>L</u> Last <u>ROBINSON</u>		4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>3</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 23, 1880</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Pipe fitter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>US Gov.</u>	
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Robinson</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Puckett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs Magdalene Robinson- Wife- Same as # 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO <u>163X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Lung Metastatic</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u> <u>1 1/2 YRS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAR.</u> , 19 <u>55</u> , to <u>3 FEB.</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3 FEB.</u> , 19 <u>57</u> , and that death occurred at <u>12 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Edward S. Beck</u> M.D. ADDRESS (Street, city or town, state) <u>Southgate Ave, Annapolis, Md.</u> DATE SIGNED PHYSICIAN'S NAME (Type) <u>Edward S. Beck</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-5-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u> ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>2/5/57</u>	
24b. REGISTRAR'S SIGNATURE <u>Wm. J. French</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1425

CERTIFICATE OF DEATH

014304

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gibson Island</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Xo Gibson Island</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Skippers Row</u>				d. STREET ADDRESS <u>Skippers Row</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Russel Joseph Savitz</u>				4. DATE OF DEATH Month Day Year <u>Feb. 6 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 30, 1894</u>		9. AGE (In years last birthday) <u>62</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plant Super.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Doughnut Mill</u>		11. BIRTHPLACE (State or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Jerome J. Savitz</u>				14. MOTHER'S MAIDEN NAME <u>Stella P. --</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Mrs/ R.J. Savitz Gibson Island</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized carcinomatosis</u> <u>177X</u> DUE TO <u>Carcinoma of prostate</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>8 months</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>June 1956</u> to <u>February 6, 1957</u> , that I last saw the deceased alive on <u>January 30, 1957</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Karl F. Mech, M.D.</u>				DATE SIGNED <u>11 E. Chase St., Balto-2, M.D.</u>			
PHYSICIAN'S NAME (Type) <u>KARL F. MECH, M.D.</u>				<u>11 E. CHASE ST., BALTO-2, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>2-8-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lou. on Park Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thelma Funeral Home - Catonsville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>11 1957</u>		24b. REGISTRAR'S SIGNATURE <u>L. J. Redman</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED: [REDACTED]
2. SEX: [REDACTED]
3. AGE: [REDACTED]
4. DATE OF BIRTH: [REDACTED]
5. PLACE OF BIRTH: [REDACTED]
6. OCCUPATION: [REDACTED]
7. CAUSE OF DEATH: [REDACTED]
8. DATE OF DEATH: [REDACTED]
9. PLACE OF DEATH: [REDACTED]
10. SIGNATURE OF PHYSICIAN: [REDACTED]
11. SIGNATURE OF REGISTRAR: [REDACTED]

BUREAU V. S.

FEB 11 1957

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FEB 11 1957
BALTIMORE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01431

Reg. Dist. No.

1426

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY IN 1b <u>16 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 1215 Dorsey Road</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u> <u>Xo2</u> d. STREET ADDRESS <u>Same</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Anna Marie Shenton</u> First Middle Last				4. DATE OF DEATH <u>February 1st.</u> <u>19 57</u> Month Day Year											
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/11/17</u>		9. AGE (In years last birthday) <u>39</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>				11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Samuel Wilkinson</u>								14. MOTHER'S MAIDEN NAME <u>Anna Smith</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>212-18-8443</u>				17. INFORMANT <u>Norman Shenton (husband)</u> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangulation by hanging herself to the railing</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>off the back porch of her home with a belt.</u> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hanging herself to the railing of porch with a belt.</u>											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>?</u> <u>2/3/57</u> <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Back porch of home</u>				20f. (City or town) <u>Glen Burnie, A.A. Md.</u>		(County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .															
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>February 4th. 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>2/6/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>				22d. LOCATION (City, town, or county) <u>Baltimore, Md.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping and Kirkley Funeral Home</u>				ADDRESS <u>Glen Burnie,</u>				24a. REC'D BY REGISTRAR <u>FEB 8 1957</u>				24b. REGISTRAR'S SIGNATURE <u>L. J. Salter</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

100-10000

BUREAU V. S.

FEB 8 1951

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Items 8,9 FilmG211 2-26-57 et
 1427
 CERTIFICATE OF DEATH

01432

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3401-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 2216 Druid Hill Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Rachel Middle Davenport Last Smith				4. DATE OF DEATH Month 2 Day 12 Year 19 57			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/25/97 1896	
9. AGE (In years last birthday) 60 99 yrs.		IF UNDER 1 YEAR Months 6 Days 9 Hours 9 Min.		IF UNDER 24 HRS. Months 6 Days 9 Hours 9 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY - -		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME Isaac Davenport				14. MOTHER'S MAIDEN NAME Linda Davenport			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		(If yes, give year or dates of service) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT State Hospital Records Crownsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 443X DUE TO Hypertensive Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Disease DUE TO (c) Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pyelitis INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/2 , 19 57 , to 2/12 , 19 57 , that I last saw the deceased alive on 2/11 , 19 57 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Lionel McHenry Mapp M.D.				ADDRESS (Street, city or town, state) Crownsville, Md.			
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.				DATE SIGNED 2/13/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 16, 1957		22c. NAME OF CEMETERY OR CREMATORY Shiloh Cemetery		22d. LOCATION (City, town, or county) (State) Northumberland Co., Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph L. Russ				ADDRESS 2222 W. North Ave		24a. REC'D BY REGISTRAR 5 3 18 1957	
				24b. REGISTRAR'S SIGNATURE H. M. Joyce			

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FEB 18 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1381

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>B.A.</u>			
3. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. J. By 64</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
4. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>R. Thomas</u> Last <u>Sr.</u>				5. DATE OF DEATH Month <u>2</u> Day <u>14</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-25-1872</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u>34</u> Days <u>14</u> Hours <u>19</u> Min. <u>57</u>		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (State or foreign country) <u>A.A. Co. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John R. Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Rachel Thomas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give branch and dates of service)				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Oliver Thomas - Annapolis, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>2-13-57</u> , 19 <u>57</u> , to <u>2-14-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2-13-57</u> , 19 <u>57</u> , and that death occurred at <u>3:33</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. T. Allen</u>				DATE SIGNED <u>2-16-57</u>			
PHYSICIAN'S NAME (Type) <u>J. T. ALLEN</u>				ADDRESS (Street, city or town, state) <u>628 P St Annapolis Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2-17-57</u>		<u>Broad Neck</u>		<u>Skidmore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr - Annapolis</u>				ADDRESS			
24a. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE			
<u>6 1957</u>				<u>Wm. J. French</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01434

1382

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2. Arnold	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital			d. STREET ADDRESS 139 Clifton Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MARY Middle LOU Last THOMAS			4. DATE OF DEATH Month Feb. Day 17 Year 1957		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 8, 1957	9. AGE (In years lost birthday) yrs. 9	IF UNDER 1 YEAR Months 9 Days 9 Hours 9 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Annapolis, Md.	
13. FATHER'S NAME George Thomas			14. MOTHER'S MAIDEN NAME Patercia R. Kenline		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. - - - - -		17. INFORMANT Address Mr George Thomas -Father- same and # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X DUE TO Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH 9 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/14, 1957 , to 2/17, 1957 , that I last saw the deceased alive on Feb. 16, 1957 , and that death occurred at 2 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 95 Cathedral St. Annapolis, Md. DATE SIGNED Feb. 20 1957					
ACTUAL SIGNATURE Neil H. Sims		M.D. 95 Cathedral St. Annapolis, Md.			
PHYSICIAN'S NAME (Type) Neil Sims MD					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-18-57		22c. NAME OF CEMETERY OR CREMATORY St. Mary's	
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME		ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

1957

NAME OF DECEASED ANDREW J. JONES		DATE OF DEATH FEB. 2, 1957	
PLACE OF DEATH HOME		CITY BALTIMORE	
AGE 45		SEX MALE	
RACE WHITE		EDUCATION HIGH SCHOOL	
OCCUPATION LABORER		MARRIAGE MARRIED	
DATE OF BIRTH FEB. 12, 1912		PLACE OF BIRTH BALTIMORE	
FATHER'S NAME JAMES J. JONES		MOTHER'S NAME MARY J. JONES	
PREVIOUS ILLNESS NONE		CAUSE OF DEATH HEART DISEASE	
IMMEDIATE CAUSE CORONARY THROMBOSIS		MANNER OF DEATH NATURAL	
SIGNATURE OF PHYSICIAN J. J. JONES		SIGNATURE OF DEATH REGISTRAR J. J. JONES	
DATE FEB. 2, 1957		PLACE BALTIMORE	

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FEB 20 1957

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01435

1428

CERTIFICATE OF DEATH

Reg. Dist. No.

INSTRUCTIONS

TO THE FUNERAL PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

50

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u> MARYLAND		STATE <u>MD.</u> COUNTY <u>ANNE ARUNDEL</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>ODENTON</u>		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>FORT GEORGE G. MEADE</u>		LENGTH OF STAY (in this place) <u>13 DAYS</u>		TOWN <u>ODENTON</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. ARMY HOSPITAL</u>		STREET ADDRESS (If rural give location) <u>7 W. TELEGRAPH ROAD</u>		STREET ADDRESS		STREET ADDRESS	
3. NAME OF DECEASED (Type or Print) <u>ROY LEE THOMAS, II</u>				4. DATE OF DEATH <u>FEB 19, 1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>CAUCASIAN</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>—</u>		8. DATE OF BIRTH <u>FEB 6, 1957</u>	
9. AGE last birthday <u>—</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROY LEE THOMAS</u>				14. MOTHER'S MAIDEN NAME <u>KAYE MARSDEN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>FATHER, ROY LEE THOMAS, 7 W. TELEGRAPH ROAD, ODENTON, MD.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
762.5 IMMEDIATE CAUSE (A) <u>Prematurity</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 Feb. 1957</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Angina</u>				Estimated days <u>Estimated</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Probable intracranial hemorrhage</u>				Estimated days <u>13 days</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>5:35 P.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6:30 P.</u> , 19 <u>57</u> , to <u>19:57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>19 Feb</u> , 19 <u>57</u> , and that death occurred at <u>5:35 P.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Richard M. McShane</u> M.D.				ADDRESS (Street, city, town, state) DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>2-26-57</u>		NAME OF CEMETERY OR CREMATORY <u>BALTO NATIONAL</u>		LOCATION (City, town, or county) (State) <u>BALTO MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>W. H. SAVIOR, BTLT, MSC</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook</u>		ADDRESS <u>1217 St Paul St Baltimore Maryland</u>	

2050191 XV2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1383

CERTIFICATE OF DEATH

01436

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>C.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x1. Gamblills</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. A. General Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Presley S. Turner</u>		4. DATE OF DEATH Month <u>2</u> Day <u>21</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-3-1882</u>
9. AGE (In years, last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>15</u> Days <u>15</u> Hours <u>15</u> Min. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Naval Acad.</u>	
11. BIRTHPLACE (State or foreign country) <u>Switzerland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Tim Turner</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Hamilton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Jola Turner - Gamblills, Md.</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-9-57</u> 19 <u>57</u> , to <u>2-21-57</u> 19 <u>57</u> , that I last saw the deceased alive on <u>2-20-57</u> 19 <u>57</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. T. Allen</u>		M.D. <u>G. T. Allen</u> DATE SIGNED <u>2-23-57</u>	
PHYSICIAN'S NAME (Type) <u>G. T. ALLEN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-24-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Tabor</u>		22d. LOCATION (City, town, or county) (State) <u>Chesterfield, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese - Annapolis, Md.</u>		ADDRESS <u>—</u>	
24a. REC'D BY REGISTRAR <u>FEB 26 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. J. Treachy</u>	

CERTIFICATE OF DEATH

1983

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Feb 26 1957</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>	
10. SIGNATURE OF REGISTRAR <i>John Doe</i>		11. SIGNATURE OF WITNESS <i>John Doe</i>		12. SIGNATURE OF WITNESS <i>John Doe</i>	
13. SIGNATURE OF WITNESS <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>		15. SIGNATURE OF WITNESS <i>John Doe</i>	
16. SIGNATURE OF WITNESS <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>	
19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>		21. SIGNATURE OF WITNESS <i>John Doe</i>	
22. SIGNATURE OF WITNESS <i>John Doe</i>		23. SIGNATURE OF WITNESS <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>	
25. SIGNATURE OF WITNESS <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Doe</i>		27. SIGNATURE OF WITNESS <i>John Doe</i>	
28. SIGNATURE OF WITNESS <i>John Doe</i>		29. SIGNATURE OF WITNESS <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>	
31. SIGNATURE OF WITNESS <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>		33. SIGNATURE OF WITNESS <i>John Doe</i>	
34. SIGNATURE OF WITNESS <i>John Doe</i>		35. SIGNATURE OF WITNESS <i>John Doe</i>		36. SIGNATURE OF WITNESS <i>John Doe</i>	
37. SIGNATURE OF WITNESS <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>John Doe</i>		39. SIGNATURE OF WITNESS <i>John Doe</i>	
40. SIGNATURE OF WITNESS <i>John Doe</i>		41. SIGNATURE OF WITNESS <i>John Doe</i>		42. SIGNATURE OF WITNESS <i>John Doe</i>	
43. SIGNATURE OF WITNESS <i>John Doe</i>		44. SIGNATURE OF WITNESS <i>John Doe</i>		45. SIGNATURE OF WITNESS <i>John Doe</i>	
46. SIGNATURE OF WITNESS <i>John Doe</i>		47. SIGNATURE OF WITNESS <i>John Doe</i>		48. SIGNATURE OF WITNESS <i>John Doe</i>	
49. SIGNATURE OF WITNESS <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>John Doe</i>		51. SIGNATURE OF WITNESS <i>John Doe</i>	
52. SIGNATURE OF WITNESS <i>John Doe</i>		53. SIGNATURE OF WITNESS <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>	
55. SIGNATURE OF WITNESS <i>John Doe</i>		56. SIGNATURE OF WITNESS <i>John Doe</i>		57. SIGNATURE OF WITNESS <i>John Doe</i>	
58. SIGNATURE OF WITNESS <i>John Doe</i>		59. SIGNATURE OF WITNESS <i>John Doe</i>		60. SIGNATURE OF WITNESS <i>John Doe</i>	
61. SIGNATURE OF WITNESS <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>John Doe</i>		63. SIGNATURE OF WITNESS <i>John Doe</i>	
64. SIGNATURE OF WITNESS <i>John Doe</i>		65. SIGNATURE OF WITNESS <i>John Doe</i>		66. SIGNATURE OF WITNESS <i>John Doe</i>	
67. SIGNATURE OF WITNESS <i>John Doe</i>		68. SIGNATURE OF WITNESS <i>John Doe</i>		69. SIGNATURE OF WITNESS <i>John Doe</i>	
70. SIGNATURE OF WITNESS <i>John Doe</i>		71. SIGNATURE OF WITNESS <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>	
73. SIGNATURE OF WITNESS <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>		75. SIGNATURE OF WITNESS <i>John Doe</i>	
76. SIGNATURE OF WITNESS <i>John Doe</i>		77. SIGNATURE OF WITNESS <i>John Doe</i>		78. SIGNATURE OF WITNESS <i>John Doe</i>	
79. SIGNATURE OF WITNESS <i>John Doe</i>		80. SIGNATURE OF WITNESS <i>John Doe</i>		81. SIGNATURE OF WITNESS <i>John Doe</i>	
82. SIGNATURE OF WITNESS <i>John Doe</i>		83. SIGNATURE OF WITNESS <i>John Doe</i>		84. SIGNATURE OF WITNESS <i>John Doe</i>	
85. SIGNATURE OF WITNESS <i>John Doe</i>		86. SIGNATURE OF WITNESS <i>John Doe</i>		87. SIGNATURE OF WITNESS <i>John Doe</i>	
88. SIGNATURE OF WITNESS <i>John Doe</i>		89. SIGNATURE OF WITNESS <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>John Doe</i>	
91. SIGNATURE OF WITNESS <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>		93. SIGNATURE OF WITNESS <i>John Doe</i>	
94. SIGNATURE OF WITNESS <i>John Doe</i>		95. SIGNATURE OF WITNESS <i>John Doe</i>		96. SIGNATURE OF WITNESS <i>John Doe</i>	
97. SIGNATURE OF WITNESS <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>		99. SIGNATURE OF WITNESS <i>John Doe</i>	
100. SIGNATURE OF WITNESS <i>John Doe</i>		101. SIGNATURE OF WITNESS <i>John Doe</i>		102. SIGNATURE OF WITNESS <i>John Doe</i>	

RECEIVED
FEB 26 1957
BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01437

1429

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u>			c. LENGTH OF STAY IN 1b <u>4 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>205 S. Hammonds Ferry Road</u>				d. STREET ADDRESS <u>205 S. Hammonds Ferry Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mae Commie Ward</u>				4. DATE OF DEATH Month Day Year <u>February 7, 19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 25/97</u>		9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>cleaning (ret.)</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Deshan Vet. Hosp. New York</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Sam Woods</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>191 20 4944</u>		17. INFORMANT <u>Mrs. Mary Jane Ward</u>		Address <u>Same As #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>445X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Nephro-Sclerosis</u> DUE TO (c) <u>Malignant Hypertension</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>4 yrs.</u> <u>15 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 24, 1952</u> , to <u>Feb. 7, 1957</u> , that I last saw the deceased alive on <u>Feb. 3, 19 57</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>106 W. Maple Road</u> DATE SIGNED <u>2/8/57</u>							
ACTUAL SIGNATURE <u>C. Milton Linthicum</u>		M.D. <u>106 W. Maple Road</u> <u>2/8/57</u>					
PHYSICIAN'S NAME (Type) <u>C. Milton Linthicum</u>		<u>Linthicum Heights, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 11/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Sharpsburg, Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard L. Smyth</u>				ADDRESS <u>Glen Burnie, Maryland</u>		24a. REC'D BY REGISTRAR <u>FEB 13 57</u> 24b. REGISTRAR'S SIGNATURE <u>W. J. Leach</u>	

CERTIFICATE OF DEATH

1957

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Name of Deceased		Date of Death	
John Doe		1957	
Age		Sex	
35		Male	
Race		Color	
White		White	
Place of Birth		Usual Residence	
New York		New York	
Cause of Death		Manner of Death	
Heart Disease		Natural	
Immediate Cause		Underlying Cause	
Myocardial Infarction		Heart Disease	
Duration of Illness		Period of Incubation	
10 days		Not applicable	
Date of Report		Signature of Registrar	
1957		John Doe	

BUREAU V. 2

1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1430

CERTIFICATE OF DEATH

01438

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A.CO., Md.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>A.A.Co., Md.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harmons</u>		c. LENGTH OF STAY IN 1b <u>50Yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harmons, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>Watts</u> Last <u>Watts</u>		4. DATE OF DEATH Month <u>2</u> Day <u>2</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/10/1865</u>
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Charles County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Harrison Watts, Harmons, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insuff.</u> <u>475X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Upper Respiratory Infection</u> DUE TO (c) <u>Senility</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>2/2/57</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 30</u> , 19 <u>57</u> , to <u>Feb. 2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb. 2</u> , 19 <u>57</u> , and that death occurred at <u>4:50 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Savage, Md.</u> DATE SIGNED <u>2/3/57</u> ACTUAL SIGNATURE <u>Frank E. Shipley</u> M.D. PHYSICIAN'S NAME (Type) <u>Frank E. Shipley</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/6/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>3b. Rest Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Harmons, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law, 802 Madison Avenue.</u>		24a. REC'D BY REGISTRAR <u>FEB 6 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Clara Shipley</u>			

BUREAU V. S.

FEB 6 1957

RECEIVED